UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
Chicago, Illinois 60604

Argued: May 3, 1982
August 18, 1982

Before

Hon. WALTER J. CUMMINGS, Chief Judge
Hon. JOHN L. COFFEY, Circuit Judge
Hon. GEORGE TEMPLAR, Senior District Judge*

No. 82-1065

CONTINENTAL MANORS, INC.,
Plaintiff-Appellee,

vs.

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, and KATHLEEN LEAK, Principal Program Representative,
Defendants-Appellants.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

No. 81 C 6082

J. Sam Perry, *Judge.*

ORDER

This is an appeal from an order granting a preliminary injunction entered in the district court for the Northern District of Illinois, Eastern Division, Honorable J. Sam Perry, presiding. The order appealed from prohibited the defendants from terminating the plaintiff's participation in the federal Medicare program based upon any determina-

* Honorable George Templar, Senior Judge for the District of Kansas, is sitting by designation.

tion of eligibility to participate in the program made prior to the date of the injunction. The court held that the manner in which the eligibility determinations were previously made by the defendants violated federal regulations and the plaintiff's right to due process and thus could not be relied upon as a basis for a termination action.

The plaintiff, Continental Manors, Inc. (Continental Manor) operates a nursing home in Dwight, Illinois providing skilled and intermediate nursing care to private and governmentally subsidized patients. On April 16, 1981 the U.S. Department of Health and Human Services, by a letter notified Continental Manor that on the basis of onsite surveys conducted in August and December 1980 it had concluded that Continental Manor no longer met the requirements for continued participation in the Medicare program as a provider of skilled nursing services. A four page Statement of the Deficiencies which the department determined posed a serious threat to both the patients' health and safety was attached to the department's letter. The facility had received prior notice of the majority of these deficiencies at the time of the 1980 surveys and had subsequently submitted a plan of correction. The letter stated that since the facility had prior notice of the deficiencies, the department expected "that each deficiency identified on the attached listing has now been corrected in an acceptable manner." The letter further advised Continental Manor that another survey would be conducted "in the near future" to determine whether the facility was presently in compliance with "all applicable Medicare conditions of participation" and if the facility still did not meet all conditions of participation its Medicare certification would be terminated upon proper notice.

The U.S. Department of Heath and Human Services again inspected the facility in July and August of 1981 to determine if the facility had complied with all of the conditions of participation. After reviewing the results of the July and August 1981 surveys and comparing them with the deficiencies found in the 1980 inspections, the Department determined that deficiencies still existed in the facility that seriously limited its capability to render adequate care and in fact the conditions then and there existing at the time continued to "immediately jeopardize" its patients. The Department notified Continental Manor of its determination by a letter dated September 24, 1981 and further informed the facility that due to its continued deficiencies its certification of eligibility for further Medicare reimbursement would terminate as of October 31, 1981. The letter also notified Continental Manor of its right to challenge the Department's decision by submitting a written reconsideration request, accompanied by any additional information of compliance or explanation of noncompliance within sixty days of the date of the notice of nonrenewal. A seven-page list of deficiencies accompanied the Department's letter.

Continental Manor requested reconsideration of the Department's initial determination and stated that appropriate corrective action would be taken, although Continental Manor contended it would take a period of at least six months to make all the necessary corrections. A partial resurvey of the facility was conducted on October 21-22, 1981 which indicated that while several previous deficiencies were corrected, numerous serious deficiencies remained with respect to Physician and Nursing Services, as well as Medical Direction and Supervision.

Continental Manor also responded to the Department's termination decision with a letter dated October 22, 1981 contesting the existence of certain of the reported deficiencies and submitted further evidence of compliance and proposed corrections on October 27, 1981. Further, representatives of Continental Manor met with Department of Health and Human Services representatives to discuss the facility's deficiencies on October 28, 1981.

Thereafter, on October 29, 1981, prior to the Department of Health and Human Services' final decision on reconsideration, Continental Manor brought this suit seeking a court injunction prohibiting the Department from terminating its participation in the Medicare program. The facility alleged that the administrative procedures used by the Department of Health and Human Services failed to comply with the substantive and procedural requirements of the Medicare Statutes and deprived the facility of an opportunity to be heard prior to termination. Continental Manor also alleged that the Department's findings of noncompliance and "immediate jeopardy" were exaggerated and erroneous.

On October 30, 1981 the district court granted a temporary restraining order prohibiting the Department from terminating Continental Manor's participation in the Medicare program. The court subsequently denied the U.S. Department of Health & Human Services motion to dismiss the plaintiff's complaint for lack of subject matter jurisdiction over the action.

The resurvey of the plaintiff's facility was completed on November 7, 1981 at which time it was determined that serious deficiencies *still* remained. Continental Manor was informed of the results of the resurvey and of the De-

partment's decision to affirm its termination decision by letter dated November 9, 1981. This letter advised the nursing home of its right to request an administrative hearing within sixty days of the decision.

On December 10, 1981, after a hearing before the court, a preliminary injunction was issued based upon the court's findings: 1.) that the Department's determination that a situation of "immediate jeopardy "to patient health and safety existed, was erroneous; 2.) that the Department had failed to consider evidence of compliance submitted by the defendants' [*sic*] subsequent to the notice of termination and 3.) that as a result of the administrative procedures followed by the defendants, Continental Manor had been denied a meaningful opportunity to be heard prior to termination contrary to the requirements of 42 U.S.C. § 1395cc(f)(2) (Supp. IV, 1980) and the due process clause of the U. S. Constitution.

Issue

Did the district court have subject matter jurisdiction over the case at bar?

This case was consolidated for decision after argument with *Americana Health Care Corp., et al* v. *Schweiker, et al.*, #81-1522, #81-2482, #81-2755, #81,2873, #81,1507 because of the similarity of the issues presented in each case. By a decision released on this day we have reversed the orders appealed from in these cases holding that the district courts were without subject matter jurisdiction over these actions. Our holding in *Americana Health Care, Inc., et al.*, is equally applicable to this case and controls the disposition of the issue presented herein.

In *Americana Health Care, Inc., et al.*, we held that the nursing home cases did not present a colorable constitu-

tional claim that the pre-termination procedures of the Department of Health and Human Services constituted a denial of due process. Absent a colorable constitution claim, the district court was without subject matter jurisdiction over the action because a "final decision" had not been reached as required by 42 U.S.C. § 405(g).[1]

We hold that the plaintiff in this case also has failed to establish a colorable constitutional claim of a denial of due process. The record in this case demonstrates that the nursing home facility was afforded more than an adequate opportunity to contest the Department of Health and Human Services' determination that the deficiencies in the facility and its operations constituted a danger to the plaintiffs [*sic*] and placed the patients health and safety in "immediate jeopardy." The facility received an initial warning period regarding its noncompliance with Medicare conditions of participation and thereafter was allowed numerous opportunities to submit new evidence of compliance and plans for correction after the initial decision not to renew the facility's participation agreement was made.

In addition the plaintiff was entitled to appeal the decision of the Department of Health and Human Services by merely requesting a post termination administrative hearing.

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1. 42 U.S.C. § 405(g) provides in pertinent part as follows:

   (g) Any individual, after any *final decision* of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. . . .

   (Emphasis added).

The basis of the district court's holding that the plaintiff's due process rights were violated was its determination that the plaintiff in fact met the Medicare conditions of participation and thus the plaintiff accordingly was denied due process because the Department reached a contrary conclusion in spite of the evidence of compliance submitted to it. This type of factual review of the Department's termination decision conducted by the court is the type of review of the Department's decision that § 405(g) was intended to restrict until such time as the Department has had an opportunity to review its own determination and reach a "final decision." The district court should have limited its review of the facts to the question of whether the Department of Health and Human Services' procedures afforded the nursing facility an opportunity to be heard in order to comport with the constitutional requirements of due process. Once the court had determined that adequate procedures existed to protect the nursing home from arbitrary termination of its Medicare provider status the court was without further subject matter jurisdiction over the case until the "final decision" was reached consistent with the requirements of § 405(g).

Were we to hold otherwise the courts could be called upon to review every case in which a Medicare provider asserts that the Department of Health and Human Services has erred in its determination of deficiencies. To allow challenges to the Department's deficiency determination to be brought prior to a "final agency decision" deprives the administrative agency of the opportunity to review and analyze its own decision, and further would simply overload the caseload of the already overburdened federal court system.

Judicial deference to the determination of noncompliance made by the U.S. Department of Health and Human Services officials is especially appropriate in light of the recent emphasis which the United States Supreme Court has placed on similar decisions made by professionals and expert administrators. Most recently in *Youngberg* v. *Romeo,* No. 80-1429, slip op. (U.S. June 18, 1982) the Supreme Court cautioned against judges substituting their decisions for those of qualified administrators in a case raising questions of the appropriate treatment of mentally handicapped persons. In that opinion the court stated:

> In determining what is "reasonable" — in this and in any case presenting a claim for training by a state — we emphasize that courts must show deference to the judgment exercised by a qualified professional. By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized. Moreover, there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions. See *Parham* v. *J.R.,* 442 U.S. 584, 607 (1979); *Bell* v. *Wolfish, supra,* 441 U.S. at 544 (Courts should not " 'second-guess the expert administrators on matters on which they are better informed.' ").

Youngberg slip op. at 15.

What was said in *Youngberg* regarding judicial respect for a qualified professional's determination is also applicable to the determination of "immediate jeopardy" to patients' health and safety made by the U.S. Department of Health & Human Services in this case. The U.S. Department's determination was made by persons trained and experienced in evaluating the health and safety requirements of nursing facilities and courts should be reluctant to set aside such determinations.

The district court in the case at bar held that 42 U.S.C. § 1395cc(f)(2) established the plaintiff's right to a pre-termination hearing and an opportunity to correct the facility's deficiencies. The basis for this holding was the district court's conclusion that a situation of "immediate jeopardy" to patient health and safety did not exist, contrary to the decision of the Department of Health and Human Services. The district court concluded that if a situation of "immediate jeopardy" did exist the plaintiff would not be entitled to a pre-termination hearing pursuant to 42 U.S.C. § 1395cc(f)(2).

It was inappropriate for the district court to substitute its determination of "immediate jeopardy" for that of the Department. As pointed out earlier, § 405(g) specifically defers review of such decisions until after a final decision is reached by the agency. The question of "immediate jeopardy" to patient health and safety is one involving the expertise of the inspectors and executive personel of the Department of Health and Human Services and the courts should defer to the expertise of the agency upon review of such determination especially where as here, the agency has not reached a "final decision."

The "Findings of Fact and Conclusion of Law" entered by the district court placed considerable emphasis on the fact that Continental Manor exhibited a willingness to remedy any deficiencies in its facility which prevented its continued participation in the Medicare program. The district court when considering this evidence of plans of correction failed to consider the need for a final date upon which conformance with conditions of participation must exist. Proposals and promises of the future correction of deficiencies must not be allowed to indefinitely extend the participation of a substandard facility in the Medicare

program. Further, the courts, like the administrators of the Medicare and Medicaid programs, must always consider the patients' health and safety foremost and thus should not give undue weight to promises of future compliance.

Since we find that the plaintiff in this action did not present a colorable constitutional claim of a denial of due process the district court was without subject matter jurisdiction over the case at bar and thus inappropriately reviewed the Department of Health and Human Services' finding of "immediate jeopardy" to patient health and safety and inappropriately set aside its decision to terminate Continental Manor's participation in the Medicare program. The order of the district court is REVERSED.

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

CONTINENTAL MANORS, INC., an Iowa corporation,

vs.

RICHARD S. SCHWEIKER, Secretary, United States Department of Health and Human Services, KATHLEEN LEAK, Principal Program Representative, Survey & Certification Operations Branch, Division of Health Standards & Quality, Health Care Financing Administration, Department of Health & Human Services, Region V, Chicago, Illinois.

No. 81 C 6082

FINDINGS OF FACT AND CONCLUSIONS OF LAW ON MOTION FOR PRELIMINARY INJUNCTION

Plaintiff, Continental Manors, Inc., has brought this suit to enjoin defendants from terminating or failing to renew the Medicare participation agreement of its intermediate and skilled care nursing home at Dwight, Illinois, and from impairing its eligibility to provide nursing home services to patients assisted by the federal Medicare and the federal-state Medicaid programs pursuant to titles XVIII and XIX, respectively, of the Social Security Act [Title 42 U.S.C. §§ 1395 *et seq.*, 1396, *et seq.*] Continental also seeks by *mandamus* to compel the defendants to comply with the procedures mandated by the Constitution and the

statutes and regulations governing Continental's right to continue as a provider in those programs. It also seeks declaratory judgment as to the meaning of certain statutes and regulations and the authority and duty of the defendants under them.

Defendants moved to dismiss plaintiff's suit, asserting lack of subject matter jurisdiction and failure to state a claim upon which relief may be granted. After thorough briefing and argument, this Court determined that it had jurisdiction over the subject matter and the parties; that the Amended Complaint states claims upon which relief may be granted; and that, due to the nature of plaintiff's claims and the irreparable injury plaintiff will suffer if judicial relief on those claims is not available at this time, plaintiff need not exhaust all administrative remedies before seeking relief from this Court. Accordingly, the Court denied defendants' motion to dismiss on November 18, 1981.

Defendants ordered plaintiff's contract terminated as of October 31, 1981. On October 30, the Court temporarily restrained the termination and, on November 9, 1981, extended its order to November 19, 1981 — the day it commenced hearings on plaintiff's motion for preliminary injunction. Without objection from defendants, it has continued its restraining order in effect during its hearings and to this date.

In considering the evidence presented, the Court is mindful that the claims asserted by plaintiff are collateral to its claim of entitlement for payment. Although the Court heard evidence regarding conditions at plaintiff's facility for the purpose of determining whether, under the circumstances of this case, injunctive relief is appropriate, the Court's function here is to determine whether the defen-

dants have acted in contravention of the due process clause of the Fifth Amendment to the Constitution or whether defendants have acted in contravention of the applicable statutes and regulations, and thus in excess of their authority. It is in this context that the Court makes the Findings of Fact and Conclusions of Law set forth below and, for the reasons contained in them, grants plaintiff's motion for a preliminary injunction.

I.

FINDINGS OF FACT

1. Plaintiff, CONTINENTAL MANORS, INC. (hereinafter, "Continental") is an Iowa corporation duly authorized to transact business in Illinois, and having its principal place of business at Sioux City, Iowa.

2. Defendants are, respectively, the Secretary of the United States Department of Health and Human Services and an official (Mrs. Leak) to whom the Secretary has delegated the authority to determine whether certain nursing homes comply with the conditions they are required to meet in order to participate in the Medicare program and to take various administrative actions to assure that the nursing homes either comply with those conditions or lose their Medicare contracts.

3. Continental, as lessee from "Dwight Continental Manor, Inc.", an Illinois corporation, operates a 92-bed intermediate and skilled care nursing home completed in 1972 at Dwight, Illinois. The lessor corporation is not a party to this action and is independent of and not affiliated with Continental in any way and has no officers or directors in common with it, the relationship between those corporations being only one of landlord and tenant.

4. Continental's nursing home at Dwight, Illinois, was completed in 1972. It was designed and constructed specifically to be used as a skilled nursing facility that provides both skilled and intermediate care. At the time it was completed, the United States Department of Housing and Urban Development was complimentary as to design and construction of the facility, and described it as "a fine example of a well conceived and functional facility that is an asset to the community."

5. From the time the facility was opened, to and including the present, it has been approved by the Village of Dwight, Illinois as complying with all of the Village's building codes and by the Illinois State Fire Marshall as complying with the Illinois Fire Prevention and Safety Code, as having "no apparent violations" and as being maintained "in a fire-safe condition."

6. The edition of the Life Safety Code of the National Fire Protection Association (NFPA) that applies to the facility involved herein is the 21st Edition, 1967.

7. Continental's Dwight nursing home entered the Medicare program in 1980 on its application and the favorable recommendation of the Illinois Department of Public Health, which is the State agency responsible initially for ascertaining whether nursing homes comply with the requirements of participation in the program. At that time, a requirement first imposed after 1972 that the walls in the central corridors of each wing of the building that houses patients not terminate at ceiling level, but extend upward past the suspended ceilings to the underside of the deck above (in this case, the roof) was noted and waived by Mrs. Leak.

8. Continental's Dwight nursing home had previously qualified with the State of Illinois as an intermediate and

skilled care facility for participation in the Medicaid program under Title XIX of the Social Act (42 U.S.C. § 1396 et seq.), and has maintained that qualification to the present time.

9. Late in 1980 or early in 1981, Continental submitted to defendants its proposed participation agreement in the Medicare program for the year 1981, and the State of Illinois forwarded to Mrs. Leak and the reports of its inspections ("surveys") of the home dated in August, 1980, as to operational matters and in December as to physical conditions. The State's reports noted some departures from requirements in both areas and the administrator's plan of corrections in the operational areas and his request for waiver of an indicated absence of certain "smoke barrier walls". The State agency recommended renewal of Continental's participation agreement for the year 1981.

10. Mrs. Leak, who has never been to the facility, reviewed the State's report and recommendations in April, 1981. Nevertheless, based only on the State reports by the State inspectors who had inspected the facility, she rejected their recommendation to renew Continental's contract and determined that the facility was out of compliance with federal conditions of participation. Instead of renewing Continental's participation agreement under a plan of correction, she prepared and sent to it a "warning letter" dated April 16, 1981, plaintiff's Exhibit "C". (Exhibits identified by letter rather than number were first submitted with plaintiff's Motion for Temporary Restraining Order or with its Memorandum Opposing Defendants' Motion to Dismiss and were admitted into evidence at the hearings on plaintiff's motion for preliminary injunction under the same identification. Exhibits identified by num-

ber were offered for the first time at the hearings on that motion.) Exhibit "C" listed as "deficiencies" the departures from compliance noted by the State and stated that they posed "a serious threat to patient health and safety". It referred to Continental's plan of correction, stated that defendants "expect" the deficiencies to have been corrected and said that the governmnet would conduct a new survey "in the near future" to determine whether the facility complied with "all applicable Medicare Conditions of Participation". It concluded with the statement that if the home were out of compliance its participation agreement would be terminated.

11. In July, 1981, a federal survey team inspected the facility with respect to the operational matters such as medical direction, nursing, record keeping, etc. This survey team found only three of the 36 operational deficiencies previously listed in the April 16, 1981 warning letter to exist as of the time of their inspection. These were: (1) that not all physicians who prescribed medications by telephone had counter-signed their orders within 48 hours; (2) that there was no "documentation" that the home's pharmaceutical services committee had approved the contents of the emergency medication kit; and (3) that the consulting pharmacist had not submitted quarterly reports to that same committee.

12. On August 10, 1981, a federal employee inspected for compliance with the NFPA Life Safety Code. That code is republished every few years in updated editions. From 1970 through October 30, 1972 the Social Security Act required nursing homes to comply with the 21st edition (1967) of the Code. (see prior law note at 42 U.S.C.S. § 1396(a)(28)(F)(i), main volume, p. 542). The Code has also been adopted by defendants' regulations (see 42 CFR

§ 405.1022), and the parties agree that it is the 21st edition (1967) that is applicable to the facility involved in this suit. The State of Illinois has its own life-safety regulations and enforces them through the State Fire Marshall.

13. The only Life Safety Code deficiency listed in the April 16, 1981 letter was the absence of "smoke barrier walls". The August 10, 1981 federal inspection did not show this deficiency to exist. In fact, those walls, which isolate each residential wing from the central core of the building and isolate certain hazardous areas from all else, had been incorporated in the original structure of the home and have been in place since 1972. The August 16, 1981 listing of their absence had been erroneous.

14. Whenever Continental has been notified of any deficiencies, it has made good faith efforts to correct them. All of the deficiencies listed in the April 16, 1981 letter have either been corrected or never existed and the defendants do not claim that any of them now exist.

15. Mrs. Leak issued to Continental a letter dated September 24, 1981 (Exhibit H) that was based upon the July and August federal inspections. In that letter she listed a number previously unnoted "deficiencies" and declared that they "immediately jeopardize" the patients. That letter stated that the defendants were then issuing Continental a "short term agreement" that "began on January 1, 1981 [9 months earlier] and will end on October 31, 1981 [5 weeks later]. It said that defendants would not renew the participation agreement, would not pay for the care of patients admitted after October 31 nor for any patients remaining in the nursing home after November 30, 1981. It also said that defendants would notify the State agency responsible for paying for the care of Medicaid patients under Title XIX of the Social Security Act

so that under the requirements of 42 U.S.C. § 1396(a)(i) the State would terminate Continental's participation in, and right to payment from, the Medicaid program.

16. Defendants did not give Continental any notice of the deficiencies listed in the September 24, 1981 letter prior to the issuance of that letter. They did not, before that date, give Continental any opportunity to refute any errors in the inspection report, to offer a plan of correction of any actual deficiencies, or to accomplish any work that might have been necessary for Continental to achieve substantial compliance.

17. Mrs. Leak testified that there are eighteen "Conditions of Participation" for skilled nursing facilities and that a deficiency noted within a "condition" would not necessarily mean that the "condition" was not met. She further testified that if there is either a deficiency which "threatens" patient health and safety, or a single "condition" that is not met, she must terminate the facility's participation and has no discretion to allow the facility to remain in the program while it is correcting those deficiencies. She stated that even if the facility is in the process of correcting its deficiencies, if they either cause a "condition" not to be met or if those deficiencies "threaten" patient health and safety she must terminate the facility's participation and does not have authority to defer her termination order for one day.

18. Mrs. Leak uses the term "threaten" to be equivalent to the statutory term "immediate jeopardy", without reference to the immediacy of the threat.

19. Mrs. Leak testified that there was no emergency situtation brought about by the deficiencies noted in any of the inspections.

20. After receipt of Mrs. Leak's September 24th letter, Exhibit "H", Continental discharged its regional manager who had been responsible for supervising compliance with standards by the homes under his supervision, including the Dwight home. It also dismissed the medical director of the Dwight home and engaged a replacement, effective about October 21, 1981. The Court notes that Dwight, Illinois, is a small, rural village located outside any metropolitan area and some 70 miles Southwest of Chicago, and that obtaining the services of physicians able and willing to serve as medical directors in such areas is difficult.

21. Continental promptly requested reconsideration and extension of the agreement pending efforts to correct the actual deficiencies noted and clear up those noted in error. Two weeks before the termination date imposed by her September 24th letter, Mrs. Leak agreed to grant reconsideration but refused any extension unless a new inspection should indicate full compliance with all applicable "conditions of participation" (Exhibit I).

22. On October 21-22, federal inspectors resurveyed the home for operational deficiencies and found that all of the three deficiencies remaining in July from the April 16, 1981 letter had been corrected and that 32 of the 40 operating deficiencies first reported on September 24, 1981 no longer existed. Of the eight remaining deficiencies, four concerned the failure of the home's medical director to perform his duties. They related to a prior medical director. The inspection was made on the first day on duty of a new medical director engaged by Continental to replace the director whose failures had occasioned the finding that the home did not meet the condition respecting medical directors. The defendants did not perform any additional inspection

of operations after that date nor did they make any attempt to ascertain what the new medical director had been doing to correct prior deficiencies before they issued their November 9, 1981 letter confirming that Continental was to be terminated from the Medicare program. Of the other four operational deficiencies, three concerned the failure of the patients' own physicians to perform timely physical examinations and write and sign progress notes and treatment orders. One related to written "goals" of patient treatments. These latter four deficiencies did not cause the home to fail to meet any of the "Conditions of Participation" in the Medicare program.

23. Commencing in October, 1981, Continental made various submissions to Mrs. Leak in an effort to show that it was attempting to bring the Dwight nursing home into full compliance and to overcome all the cited deficiencies. These submissions included telephone discussions between Mrs. Leak and Continental's architects and engineers, conferences with its attorneys, and documents and factual statements supplied by Continental's attorneys. As examples, Continental submitted an improvement program prepared by architect Howard Heil of FEH Associates and a safety survey prepared by safety engineer Robert Barnes of Gage-Babcock associates, plans for the installation of a sprinkler system for the entire structure, factual statements concerning the installation of three of the five required fire doors and the ordering of two others, factual statements concerning the compliance of the corridor walls with the 1967 NFPA Life Safety Code, and a letter by the State Fire Marshall stating that on October 19, 1981, he found no apparent violations of the State's fire prevention and safety rules, and other items. (See Exhibits "A", "B", "D", "E", "F", "G", "J", "K", "L", and "N".)

24. Mrs. Leak testified that she was "aware" of these submissions but they were not entitled to any weight because they did not establish that the deficiencies listed in her September 24, 1981 letter had been corrected. The Court finds that these submissions were entitled to weight because they showed how certain deficiencies were listed in error, that certain deficiencies had been corrected, and what was being done with respect to the deficiencies that could not be corrected prior to October 31, 1981. (See. *e.g.* Exhibit L). Moreover, the Court finds that Mrs. Leak had no basis for believing those submissions not to be true and accurate. To the extent that any of the representations made to Mrs. Leak have been checked out, they have been shown to be correct.

25. It is apparent from Mrs. Leak's testimony that while she will look at written submissions presented to plaintiff and listen to oral representations made by plaintiff, in making her decision the only information to which she will give any weight is that provided by her own survey teams.

26. On November 2, 1981, a federal engineer resurveyed the nursing home for compliance with the NFPA Life Safety Code, 21st Edition, 1967. His report eliminated some of the items previously listed as deficiencies: A hold-open device on a door between kitchen and dining room, corrected by a simple adjustment to the closer; smoke doors activated by a single safety-device, corrected by discovery that he had overlooked the other devices that activated them; make-up air for laundry dryers taken from corridor, corrected by discovery that he had overlooked the air supply ducts; no make-up fresh air supply for heater (boiler) room, corrected by discovery that he had overlooked the supply ducts; inadequate "fire protection plan", corrected by discovery of adequate plan upon inquiry. (See Exhibit "O").

27. The engineer's report of November 2 retained as deficiencies the failure of the corridor walls to extend upward beyond the ceilings to the deck above and certain wire glass openings that exceeded permissible size, the absence of documentation of the "flame spread rating" of the interior walls of a chapel and the absence of five "labeled fire doors". The report added that a door between the dining room and the corridor was being held open.

28. With respect to the corridor walls, defendants contend that section 10-133 of the 1967 NFPA Life Safety Code requires the corridor walls to extend to the roof deck. Defendants concede that this section of the 1967 Code does not state that corridor walls must extend to the roof deck but claims that they are "interpreting" this section to include this requirement on the basis of later editions of the Code that defendants conceded were not published until after this home was constructed and are not applicable to Continental.

29. Section 10-133 of the 1967 edition of the NFPA Life Safety Code provides in pertinent part: "[a]ny corridor shall be separated from institutional sleeping rooms and treatment areas by construction having at least a one-hour fire rating." The walls separating the residential rooms from the corridors and the ceilings in the rooms are fire code C gypsum-board that has at least a one hour fire rating. The ceilings in the corridors are mineral tiles set into steel frames and these ceilings also have at least a one hour fire rating. The Court finds that the corridors are separated from the sleeping rooms and treatment areas by construction having at least a one hour fire rating.

30. With respect to the Chapel walls, Continental has introduced into evidence documentation indicating that the

wood paneling has been treated with a finish that has a flame spread rate that is less than the maximum flame spread rate permitted by the Code and the acrylic panels are made of "KRINKGLAS" which is a non-burning material (see plaintiff's exhibits 8, 9, 15 and 16). This documentation was not submitted to Mrs. Leak until after her decision was made. However, Mrs. Leak testified that this documentation would not have any effect on her decision. The Court finds that this documentation is relevant because the deficiency listed with respect to the Chapel walls is lack of documentation on the flame spread rating and this documentation should be considered and given weight in any future decision defendants make regarding the Chapel walls.

31. On November 9, 1981, the Department issued its letter confirming that it would not renew Continental's contract on the basis of non-compliance with the medical direction Condition and the life-safety Condition. That letter, Exhibit "O", was prepared by defendant Leak and submitted through her superiors to Mr. Philip Nathanson, the Department's Regional Administrator, as the individual making an "independent" reconsideration of the decision not to renew Continental's contract. The documents submitted to Mr. Nathanson consisted of the letter prepared by Mrs. Leak and her summary of the inspection reports of October 21-22 and November 2, 1981. The submissions of Continental were not included. Mr. Nathanson signed the letter without change, and it was then issued. Mr. Nathanson did not take into consideration any of the efforts of the plaintiff to achieve compliance or any accomplishments that may have been achieved after October 31, 1981. In making their decision, Mrs. Leak and Mr. Nathanson considered only the reports of the federal inspectors and

their own interpretations of the governing statutes, regulations and NFPA's 1967 Life Safety Code.

32. As noted in Finding of Fact number 26, the November 2, 1981 inspection showed that many of the Life Safety Code deficiencies listed in the September 24, 1981 letter either never actually existed or have been corrected. Mrs. Leak testified that these non-existent or corrected deficiencies were each important factors in her September 24, 1981 finding of "immediate jeopardy" and, although the November 9, 1981 letter confirms the September 24th letter's decision to terminate Continental's participation without an opportunity to correct, the November 9th letter makes no finding of "immediate jeopardy".

33. Mrs. Leak was the official who terminated the eligibility of Northlake Community Hospital to receive Medicare payments. (See *Northlake Community Hospital* v. *United States,* 654 F. 2d 1234 (7th Cir. 1981)). She testified that Northlake had serious Life Safety Code deficiencies that immediately jeopardized patient safety. Nevertheless she allowed Northlake two years to correct those deficiencies before terminating its continued participation. In the present case, she allowed Continental less than 5 weeks to extend its corridor walls to the roof deck, rebuild the Chapel walls, install or modify door-closing devises, and install labeled fire doors or, alternatively, install a full sprinkler system, or face termination. The Court finds that defendants must have known it to be impossible to accomplish all of the above within 5 weeks. Unless an emergency situation exists that requires immediate evacuation of the patients for the protection of their lives, the imposition of such a time schedule to correct deficiencies is unreasonable and therefore violates 42 U.S.C. § 1395cc(f)(2).

34. Mrs. Leak testified that no emergency exists at Continental. Moreover, she testified that if a patient at Continental should not be moved for medical reasons, Continental could continue to care for such patients under the Medicare program. Not only is this inconsistent with any finding of "immediate jeopardy" but the delay between the Life Safety Code inspection of August 10, 1981 and the termination letter of September 24, 1981 shows that neither Mrs. Leak nor the inspector believed that "immediate jeopardy" actually existed.

35. Continental does not desire to simply meet minimum standards, but seeks to maintain and operate a superior nursing home. The Life Safety Code deficiencies listed by defendants were not the result of Continental attempting to save money by cutting corners. For example, wood paneling and KRINKLGLAS panels were used in the Chapel to create a pleasant atmosphere for the patients and the Court notes that their use was obviously more costly than the gypsum board that could have been used. Moreover, in order to maintain this atmosphere and comply with the requirements claimed to be necessary by defendants, Continental is having a new complete sprinkler system installed throughout the home, even though it is not required to do so by law.

36. The Omnibus Reconciliation Act of 1980 (P.L. 96-499, Title IX, part A, subpart II, § 916(a), 94 Stat. 2623) incorporated into § 1866 of the Social Security Act (42 U.S.C. § 1395cc) new provisions (subsection (f)), effective December 28, 1980. Under this Act, when deficiencies are found, the Secretary is to determine whether the nursing home no longer meets the Conditions of participation in the Medicare program and then is to determine whether or not its deficiencies "immediately jeopardize the health and

safety of its patients." If they do, he is to terminate its participation and cease payments (and order State agencies to cease payments) with respect to persons admitted after the termination date. If the deficiencies do not create "immediate jeopardy", the Secretary may terminate participation or cease payments, but only *after* the facility has had "a reasonable opportunity, *following* the initial determination . . . to correct its deficiencies, and, *following* this period, has been given reasonable notice and opportunity for a hearing." (Underline added.) A decision to deny payments becomes ineffective as soon as the facility is in substantial compliance with the Conditions "or is making good faith efforts to achieve substantial compliance" with them.

37. The regulations adopted by the Secretary have not been updated to reflect the Omnibus Reconciliation Act of 1980. However, the procedures found in the existing regulations are adaptable to that Act. (See 42 CFR § 405 and the subsections thereof; the subsections will here be designated with "¶" marks, so that 42 CFR §405.1502, for example, is referred to only as ¶1502.)

¶1502 requires the Secretary to make (1) *findings* and (2) an *initial determination* before terminating a facility from the Medicare program.

¶1505 provides that the *findings* that deficiencies exist are *not* to be considered "initial determination".

¶1907 provides that a facility with deficiencies may continue to participate under a plan of correction and that it will have a reasonable time to come into compliance.

¶1908 applies to skilled nursing facility such as the Dwight Continental Manor. It restricts certification to a period of not over 60 days after the end of the time allowed

for corrections unless the corrections are made by then or the facility has made substantial effort and progress in correcting deficiencies.

¶1504 provides for reconsideration of "initial determinations", as does ¶1510.

¶1515 states that the Secretary will receive any documents or written statements in evidence on reconsideration and will base the reconsideration determination "on the evidence considered in making the initial determination and *whatever other written evidence that is submitted prior to the time of the reconsidered determination,* taking into account facts . . . *as of a date subsequent to the initial determination.*" (Underline added.)

38. Defendants did not give Continental any notice of any "Finding" of deficiencies listed in Exhibit "H" before September 24, 1981.

39. Defendants did not permit Continental to continue to participate under a plan of correction providing a reasonable time to come into compliance with the Conditions of participation.

40. Defendants did not recognize as relevant to their initial determination to terminate Continental's participation nor to their reconsidered determination (Exhibit "O") any plan of correction or any efforts to correct deficiencies or any attempt to show that purported deficiencies did not exist.

41. Mrs. Leak testified that the nonrenewal of Continental's contract would not cause it to lose any residents, but would only cause the loss of federal and State payments for the care of about 10 patients receiving skilled nursing care under the Medicaid program of Title XIX of the Social Security Act. Plaintiff points out that Mrs.

Leak's finding that the alleged deficiencies "immediately jeopardize" the Medicare (Title XVIII) patients will cause both the Department and the State to terminate Continental's participation and to cease all payments for patients receiving either skilled or intermediate care under Title XIX, pursuant to the provisions of § 1396a(i)(1) of Title 42 U.S. Code, and that more than 40 patients (about half of the total) would thus lose their benefits if remaining in the facility. In either case, Continental would suffer immediate and irreparable injury.

42. If allowed by the Court to take place, the effect of terminating Continental's continued participation will be (1) to prevent Continental from accepting any Medicare patients who may require skilled nursing care; (2) to cause the Illinois Department of Public Health and the Illinois Department of Public Aid to terminate Continental's eligibility to receive Medicaid payments under Title XIX of the Social Security Act for the care of approximately 40 persons receiving public assistance; (3) to create a default situation under its lease with Dwight Continental Manor, Inc. and possibly to cause it to lose that lease and discontinue all nursing home operations at Dwight. The plaintiff would suffer immediate and irreparable harm on account of the nonrenewal of its contract.

43. The defendants and the public would suffer no harm and incur no added costs because of the issuance of an order enjoining nonrenewal, because the patients would have to be paid for at some other facility, if not at Continental Manor. On the other hand, the residents would suffer harm by being forced to move from their homes and friends and, possibly, from the community of Dwight. The Village of Dwight would lose the availability of the nursing home in the community and the convenience, as well as the employment, that it provides.

44. On balance, the issuance of the preliminary injunction would favor the public interest as well as that of the plaintiff without imposing any particular or added burden on the defendants.

II.

CONCLUSIONS OF LAW

A. As previously determined, this Court has jurisdiction of the parties and the subject matter of this action.

B. Plaintiff has stated claims upon which relief can be granted.

C. Plaintiff has contractual rights and expectations to continue its participation as a provider of skilled nursing home services in the ongoing federal Medicare programs created by Title XVIII of the Social Security Act (42 USC § 1395 et seq). These rights and expectations are property rights under the laws of Illinois and The United States and are protected under the due process clause of the Fifth Amendment to the Constitution of the United States.

D. Defendants have certain duties imposed upon them by Title XVIII and the regulations promulgated by the Department of Health and Human Services setting forth the steps they must take and the matters they must consider before terminating plaintiff's contractual rights or refusing to renew its participation agreements, and actions taken in derogation of those duties are taken in excess of their authority under the statute and regulations.

E. The provisions of 42 USC § 1395cc(f), enacted as part of the Omnibus Reconciliation Act of 1980, effective December 5, 1980, P.L. 96-499, Title IX, part A, subpart II, § 916(a), 94 Stat 2623, require the Department to act as

follows in terminating the participation of a skilled nursing facility and in safe-guarding its rights: First, the Department must determine whether the facility is out of compliance with the conditions of its participation in the Medicare program, as set out in §1861(j) of the Social Security Act [42 USC § 1395x(j)]. Then it must determine whether the deficiencies "immediately jeopardize" the health and safety of the facility's patients. If "immediate jeopardy" exists, termination is mandatory on short notice. If "immediate jeopardy" does not exist, the Department must make another decision, which is whether to terminate the facility's participation or merely to deny federal payments and order the cooperating State agencies to deny payments under the Medicaid program of Title XIX of the Social Security Act (42 USC § 1396, *et seq.*)

However, *before* making this decision, and thus *before* either terminating participation or suspending payments, the Department is required to allow the facility a reasonable opportunity to correct its deficiencies and then reasonable notice and opportunity for a hearing. If the decision is to deny (suspend) payments, the effectiveness of the denial or suspension ends when the facility has either achieved substantial compliance with the conditions of participation or is making good faith efforts to achieve substantial compliance. Parallel provisions govern State officials under the companion Medicaid law, 42 USC § 1396a(i), as to both skilled and intermediate care facilities.

F. Under the Omnibus Reconciliation Act, the Department may terminate a facility without allowing time to correct its deficiencies only if those deficiencies create "immediate jeopardy". The determination that a facility is out of compliance with the conditions is not sufficient basis for termination without reasonable opportunity to correct deficiencies unless "immediate jeopardy" exists.

G. Defendants have taken the position that if a facility is no longer in substantial compliance with the conditions of participation, they have no discretion but are required to terminate its contract forthwith, regardless of whether "immediate jeopardy" or even a "serious threat" to the patients' health and safety exists. That position is erroneous as a matter of law, and, to the extent that they have acted in accordance with it in terminating (or, as they put it, "nonrenewing") Continental's participation agreement the defendants have acted in excess of their statutory authority.

H. "Immediate jeopardy" portends conditions so dangerous that delay in removing patients from the facility for sufficient time to permit it to correct those conditions could not be countenanced; it means an emergency situation of immediate hazard. *Hathaway* v. *Mathews*, 546 F. 2d 227, 231 (7th Cir., 1976). All deficiencies in meeting the elements and standards of the conditions of participation must pose some hazard, danger or jeopardy to the patients; otherwise the imposition of those conditions would be pointless and unreasonable. It is presumed that Congress intended the word "immediate" to have substantive meaning and that it is not mere surplusage in the Act. Thus the defendants' determination that Continental's patients were in "immediate jeopardy" as of September 24, 1981, was required to be based upon some perceived emergency. While "threatens" may be equivalent to "jeopardy" it is not equivalent to "*immediate* jeopardy". Mrs. Leak's testimony that certain deficiencies "threaten" patient health and safety does not rise to the level of the statutory criterion of "immediate jeopardy". Defendants have no statutory authority to declare that deficiencies "immediately jeopardize the health and safety of its patients"

unless such an emergency exists, and a determination of "immediate jeopardy" without an emergency contravenes the statute and is beyond their authority.

I. The testimony of Mrs. Leak that there was never an emergency situation at Continental's Dwight nursing home is inconsistent with the determination reflected in her letter of September 24th to the facility that its patients were "immediately jeopardized" by its deficiencies.

J. Mrs. Leak's testimony that if a patient at Continental should not be moved for medical reasons, Continental could continue to care for such patients under the Medicare program is inconsistent with any finding of "immediate jeopardy".

K. The actions of the defendants in waiting six weeks before notifying Continental or the State agencies of the alleged deficiencies and permitting Continental to accept new patients for five weeks longer, and authorizing it to continue caring for all patients for four more weeks, or even longer if other facilities were not available, are inconsistent with a situation of emergency or immediate jeopardy.

L. As a matter of law, the determination by defendants on September 24, 1981, that Continental's patients were in immediate jeopardy was without foundation and, therefore, in excess of defendants' statutory authority.

M. The Court has heard the testimony of Mr. Clinton Gehring for the plaintiff and of Mrs. Leak, one of the defendants, and considers both of them to be sincere and well-motivated individuals. No issue has been raised as to their credibility. The Court has received considerable documentary material into evidence for the limited purpose of the hearing on the plaintiff's motion for preliminary in-

junction, and has given it such weight for the purposes of the hearing as seems appropriate, mindful that much of it is not actual proof of facts but is only indicative of the facts that are likely to be proved by more direct evidence upon trial of this case. This evidence establishes clearly that there was not and is not any immediate jeopardy to the patients of Continental resulting from its deficiencies.

N. The finding of "immediate jeopardy" in Mrs. Leak's September 24, 1981 letter to Continental was based upon a number of reported deficiencies, many of which were erroneously noted or have been corrected. Although Mrs. Leak declined to indicate which was the most serious of them, her testimony indicated that she believed the fact that the corridor walls do not extend to the roof deck was the most serious. Her claim that the corridor walls must so extend is based upon her "interpretation" of the 1967 Life Safety Code that is, at best, questionable. That edition of the Code is a "performance" code, not a "means" regulation, and in requiring a one-hour fire separation between corridors and patient residential or treatment rooms, it did not specify how that separation was to be accomplished. The design and construction of Continental's home provides this one-hour fire separation. The defendants concede that it is the 1967 edition of the Code that is applicable and the Court notes that at the time the home was constructed the statutes provided that the 1967 edition of the Code governed nursing home construction. (*See*, 42 USCS § 1396(a)(28)(F)(i), former statute, at p. 542, main volume). Defendants' attempt to "jump codes" by "interpreting" the 1967 edition so as to add to it requirements found in later editions that are not applicable to Continental exceeds defendants' authority. Moreover, even if defendants had the authority

to impose conditions not contained in the applicable Code, fundamental concepts of fairness would require that Continental be given adequate notice of this new requirement and a reasonable amount of time to comply with it. Continental has not attempted to use a "grandfather clause" in order to avoid expeditures. It is having a new sprinkler system installed that defendants concede will cure any and all of the listed Safety Code deficiencies. Continental expects to have that sprinkler system completed in three months, which is well within a reasonable time. The Court concludes that even if defendants could impose new requirements not specified in the applicable Code, defendants' refusal to allow Continental a reasonable time to comply, especially in light of Continental's good faith efforts to achieve compliance, violates the statutes, contravenes the most fundamental concepts of fairness, and violates the due process clause of the Fifth Amendment.

O. The "immediate jeopardy" determination was also based upon a failure to document that the interior finish on the walls of a small chapel built within the living-room wing, and not within any residential wing, of the nursing home had a certain flame-spread rating. At the hearing, after Continental had presented laboratory test reports indicating that the interior finish (as well as certain acrylic panels) was incombustible and would not support any flame, Mrs. Leak testified that by "interior finish", she meant the material of the chapel walls themselves: the wood panelling to which the finishing stain, sealer and varnish were applied. Even assuming such an interpretation to be permissible, nothing in the September 24th letter would require anything more than those laboratory reports in order to clear the deficiency noted. Furthermore, she testified that if Continental had provided the documentation

she would not have given it any weight and it would not have influenced her determination of immediate jeopardy. Although the presence or absence of documents may not create immediate jeopardy, their presence can indicate whether or not it exists. Consequently, Mrs. Leak is required, as a matter of law, to consider and weigh plaintiff's documentation on flame-spread characteristics before finding "immediate jeopardy". As a matter of fundamental fairness, the defendants may not terminate the contract on the basis of an unstated deficiency while rejecting evidence that the stated one does not exist. As this matter was an "important consideration", according to Mrs. Leak, her determination of "immediate jeopardy" is further depleted of legal foundation.

P. Several additional noted deficiencies were later found not to exist and to have been noted in error by the federal inspectors. Mrs. Leak's testimony that she regarded each of them as an "important consideration" in her determination of "immediate jeopardy" further weakens the basis for that determination.

Q. Some deficiencies had been corrected before the hearings on this motion and before the issuance of the defendants' letter of November 9, 1981, confirming the termination. These were described to Mrs. Leak in the letters submitted to her by plaintiff's counsel. She testified that she gave no consideration to improvements made after October 31 because that was the date she had set for the expiration without renewal of the contract. Entirely apart from the effect of this Court's order prohibiting termination on that date or before further order of the Court, the regulations of the Department require that consideration be given to matters submitted up to the time that a "reconsidered determination" is made. [42 CFR § 405.-

1515.] By declining to consider improvements made at least up to November 9, 1981, defendants violated their own regulations.

R. It is also apparent from Mrs. Leak's testimony that she gave no weight to any materials from any source other than the Department's own inspection teams at any point in the "reconsideration" procedure, and that Mr. Nathanson did not have before him on November 9, 1981, any of plaintiff's submissions. The regulation at 42 CFR § 405.-1515 provides that "The reconsidered determination will be based on the evidence considered in making the initial determination and whatever other written evidence that is submitted prior to the time of the reconsidered determination, taking into account facts relating to the status of the institution . . . as of a date subsequent to the initial determination." The issuance of the reconsidered determination affirming the nonrenewal of Continental's contract was thus made in contravention of Departmental regulations and is void as a matter of law.

S. Because, as a matter of law, there is no basis of a finding of immediate jeopardy, defendants' refusal to consider Continental's good faith efforts to achieve compliance violates 42 USC § 1395cc(f)(3) which provides that "good faith efforts to achieve substantial compliance" is a criterion that is to be considered.

T. The November 9th decision does not contain a determination of "immediate jeopardy", but merely reaffirms the decision to terminate without such a determination. Because the statute does not authorize termination in the absence of "immediate jeopardy" except after the facility has had a reasonable opportunity to correct its deficiencies [42 USC 1395cc(f)(2)], the "reconsidered

determination" of November 9, 1981, was in excess of defendants' authority and void on its face.

U. The defendants have denied Continental all opportunity to be heard at a meaningful time or in a meaningful manner, thus depriving it of its protected property rights without due process of law.

V. Continental has a likelihood of success of proving at trial that defendants have acted in contravention of the due process clause of the Fifth Amendment to the Constitution of the United States.

W. Continental has a likelihood of success of proving at trial that defendants have violated the applicable statutes and regulations and thus exceeded their authority when they attempted to terminate Continental's continued participation in the Medicare and Medicaid programs.

X. Continental has a likelihood of success of proving at trial that if defendants were to follow the applicable statutes and regulations, there would be no legitimate basis for terminating Continental's continued participation in the Medicare and Medicaid programs.

Y. Continental has a likelihood of success of proving at trial that defendants have misconstrued the applicable statutes and regulations and that if those statutes and regulations are properly construed and applied, there would be no legitimate basis for terminating Continental's contined participation in the Medicare and Medicaid programs.

Z. The administrative procedures of defendants for review of their decisions thus far made are inadequate to prevent plaintiff from suffering irreparable harm as the result of its disqualification from the Medicare and Medicaid programs while these procedures grind in their conclusion.

AA. If a preliminary injunction is not issued and the plaintiff's contract is permitted to terminate, the harm to the plaintiff will be great and irreparable; whereas, the issuance of a preliminary injunction will not cause the government any additional cost or expense in caring for Continental's patients nor expose the patients to any significant hazards. The interests of the people and the Village of Dwight would be served by the continued availability of Continental Manor as a residence and long-term care facility for Medicare and Medicaid patients and as a source of employment. Thus the equitable considerations of irreparable harm to the plaintiff, no harm to the defendants, benefits to the patients and the public, and likelihood of success at trial are all with the plaintiff.

BB. Any Findings of Facts which contain or might be considered to be Conclusions of Law are incorporated here without restatement, and any statements of fact found in these Conclusions of Law are incorporated in the Findings of Fact.

CC. Continental Manors, Inc. is entitled to the issuance of a preliminary injunction, enjoining and restraining the defendants from terminating or permitting the expiration of or failing to renew upon expiration plaintiff's Medicare participation agreement on the basis of any of defendants' determinations heretofore made, until further Order of this Court after trial of this cause.

J. S. PERRY
United States District Judge

Chicago, Illinois,
December 10, 1981,
10:00 o'clock, A.M.

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

CONTINENTAL MANORS, INC., an Iowa corporation, vs. RICHARD S. SCHWEIKER, Secretary, United States Department of Health and Human Services, KATHLEEN LEAK, Principal Program Representative, Survey & Certification Operations Branch, Division of Health Standards & Quality, Health Care Financing Administration, Department of Health & Human Services, Region V, Chicago, Illinois.	No. 81 C 6082

PRELIMINARY INJUNCTION

1. Until further Order of this Court defendants Schweiker and Leak and their successors in office and all persons acting or purporting to act pursuant to their direction, under their authority or in consequence of their decisions be and they are hereby enjoined and restrained from terminating, causing to be terminated, or failing to renew upon expiration and application for renewal for the years 1981 and subsequent years the participation agreement between Continental Manors, Inc. and the Department of Health and Human Services, Health Care Financing Administration, qualifying Continental Manors, Inc.'s nursing home at Dwight, Illinois, as a provider of skilled nursing home services under Title XVIII of the Social Security Act and from directing, inducing or encouraging any officer of the State of Illinois to terminate or fail to renew any

contract, qualification, eligibility or licensure for the operation of plaintiff's nursing home at Dwight, Illinois, and its participation in the Medicaid program as a provider of intermediate or skilled nursing home services under Title XIX of the Social Security Act, on account of any of the determinations heretofore made by defendants as cause for such termination or nonrenewal of plaintiff's participation agreement.

2. Defendants are directed to circulate and distribute copies of this Preliminary Injunctive Order and the Findings of Fact and Conclusions of Law upon which it is based as widely and to the same persons as those to whom they distributed their letters of September 24 and November 9, 1981 or distributed or published any notice concerning them.

3. In the event of any appeal of this Order, this Order shall remain in full force and effect pending determination of the appeal unless vacated or modified by the United States Court of Appeals for the Seventh Circuit or the Supreme Court of the United States, as the case may be.

4. Plaintiff has deposited with the Court the Certificate of Insurance of Financial Guardian Insurance Co. and Northbrook Insurance Co. to the effect that plaintiff's potential liability for harm or injury to the residents of its nursing home at Dwight, Illinois, is insured to the extent of $5,000,000.00, and the Court accepts that Certificate in lieu of any bond which might otherwise be required in respect of the issuance of this Preliminary Injunction.

ENTER:

J. S. PERRY
United States District Judge

Issued at Chicago, Illinois,
this 10th day of December, 1981,
at 10:00 o'clock, A.M.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V

175 W. Jackson Boulevard
Chicago, Illinois 60604

Health Care Financing
Administration

November 9, 1981

Refer to: CO11
Provider Number: 14-5399
Mr. Vincent Ketzle
Administrator
Continental Manor of Dwight
300 East Mazon Avenue
Dwight, Illinois 60420

Dear Mr. Ketzle:

As you are aware, we advised you that we did not intend to renew Continental Manor of Dwight's provider agreement effective November 1, 1981. Upon receipt of our notification of this decision, you requested that we reconsider our decision and advised us that Continental Manor of Dwight was attempting to come into compliance with all the applicable Medicare Conditions of Participation for Skilled Nursing Facilities. In order to determine the validity of this assertion, we scheduled a partial direct federal survey at Continental Manor of Dwight. The results of that resurvey, which was conducted on October 21-22 and November 2, 1981 indicated that Continental Manor of Dwight is not in compliance with all the applicable Medicare Conditions of Participation. The list of deficiencies which was identified during the partial survey is attached.

Therefore, we regret to inform you that we must reaffirm our initial decision.

You may, of course, take steps to come into compliance with the Medicare Conditions of Participation and reapply to establish your eligibility to participate as a provider of services under Title XVIII of the Social Security Act. The Illinois Department of Public Health is available to provide any consultation or assistance you may need in order to accomplish this.

If you do not believe that this decision is correct, you may request a hearing. Your request for a hearing must be submitted in writing within 60 days of the date of this notice. Your request for a hearing should be addressed to the Director of Hearings Staff, Office of Eligibility, Bureau of Program Policy, Health Care Financing Administration, East Building, Room 189, 6325 Security Boulevard, Baltimore, Maryland 21207.

The request for a hearing should state why you consider that our decision is incorrect and should be accompanied by any evidence and arguments which you may wish to bring to the attention of a hearing examiner. Evidence and arguments may also be presented by your counsel at the hearing.

Sincerely yours,

Philip Nathanson
Regional Administartor

Attachment
cc: Senator Charles Percy
Senator Alan Dixon
Representative Tom Corcoran

STATEMENT OF DEFICIENCIES

Continental Manor of Dwight
300 East Mazon
Dwight, Illinois 60420

Dates of Federal Surveys:
October 21-22, 1981
November 2, 1981

This facility is not in compliance with the following Medicare Conditions of Participation for Skilled Nursing Facilities:

Section 405.1122 — Condition III — Medical Direction

A. Coordination of Medical Care — This standard is not met. There is no documentation which indicates that the medical director was coordinating medical care in this facility. The medical director has failed to ensure that physician orders are signed, to ensure that physical examinations are done and/or done on a timely basis, and to ensure that progress notes are written as required. This is a repeat deficiency.

B. Responsibilities to the Facility — This standard is not met due to the existence of the following deficiencies:

1. The medical director did not assume responsibility for surveillance of the health status of the facility's employees. Of nine personnel folders reviewed, four lacked current physical examinations.

2. There is no documentation which indicates that reports concerning incidents and accidents which occur on the premises are reviewed by the medical director to identify hazards to health and safety.

3. There is no documentation which indicates that the medical director has provided the administrator with appropriate information to help ensure a safe and sanitary environment for patients and personnel.

These are repeat deficiencies.

Section 405.1134 — Condition XV — Physical Environment

A. Life Safety From Fire — This facility is not in compliance with all applicable provisions of the National Fire Protection Association's Life Safety Code (21st Edition, 1967) due to the existence of the following deficiencies:

1. Corridor walls do not extend to the underside of the roof deck above, and there are openings in the corridor walls which exceed 1,296 square inches in size and 54 inches in either length or width. This is a repeat deficiency.

2. Door between the corridor and the dining room is being held open.

3. The interior finish of the walls of the chapel is not class A or B. The chapel walls consist of wood paneling, plastic or acrylic translucent panels, and a folding door. In the absence of documentation which indicates that the flame spread rating of these "walls" is 75 or less, these "walls" are not acceptable, and the area must be sprinklered. This is a repeat deficiency.

4. The laundry is neither equipped with labeled fire doors nor an acceptable sprinkler system. Piping for the current sprinkler system is not adequate in size, the sprinkler system valve is not an indicating valve. This is a repeat deficiency.

5. The clean linen room next to the laundry is neither sprinklered nor equipped with a labeled fire door. This is a repeat deficiency.

6. The soiled linen room is neither equipped with an adequate sprinkler system nor labeled fire doors leading to the laundry and to the corridor. This is a repeat deficiency.

7. The kitchen lacks labeled fire doors. Also, if the dining room is considered to be part of the kitchen, the dining room would also require labeled doors. This is a repeat deficiency.

In addition to the conditions which are not met, this facility is not in compliance with the following supporting standards and elements which are contained in the Medicare Conditions of Participation for Skilled Nursing Facilities:

Section 405.1123 — Condition IV — Physician Services

B. Patient Supervision by Physician — The following deficiencies exist in this area:

1. The medical evaluation of each patient is not based upon a physical examination done within five days prior to, or 48 hours subsequent to, admission. For example, patient #81-42 was admitted on August 5, 1981. This patient's physical examination was not done until August 27, 1981. Also, there was no indication that physical examinations were done at all for patients #80-4 and #81-17A. This is a repeat deficiency.

2. Progress notes are not being written and signed by the attending physician at the time of each visit. This is a repeat deficiency.

3. All orders are not signed by attending physicians. For example, physician orders given for patient #80-4 during June, July and August were not signed. This is a repeat deficiency.

Section 405.1124 — Condition V — Nursing Services

D. Patient Care Plan — This standard is not met. Care plans lack clearly defined goals and specific time frames for reaching those goals that are written. Also, care plans do not always contain input from all services. Deficiencies have been cited in this area in the past.

AMERICANA HEALTHCARE CORPORATION, et al.,

Plaintiffs-Appellees,

v.

RICHARD SCHWEIKER, Secretary of Health and Human Services,

Defendant-Appellant.

TURTLE CREEK CONVALESCENT CENTERS, INC., d/b/a Northside Healthcare Center,

Plaintiff-Appellee,

v.

RICHARD SCHWEIKER, Secretary of Health and Human Services,

Defendant-Appellant.

CARE INNS, INC., d/b/a Clarksville Healthcare Center,

Plaintiff-Appellee,

v.

ROBERT F. SMITH, Acting Administrator, DONALD L. BLINZINGER, Administrator of Indiana State Dept. of Public Welfore, and The Indiana Dept. of Public Welfare,

Defendants-Appellants.

CARE INNS, INC., d/b/a Clarksville Healthcare Center,

Plaintiff-Appellee,

v.

RICHARD SCHWEIKER, Secretary of the Department of Health and Human Services,

Defendant-Appellant.

LAURA HATHAWAY, d/b/a R. N. Nursing Home, and Judy Carrothers,

Plaintiffs-Appellees.

v.

RICHARD SCHWEIKER, Secretary of Health and Human Services,

Defendant-Appellant.

Nos. 81-1522, 81-2482, 81-2755, 81-2873 and 81-1507.
United States Court of Appeals, Seventh Circuit.
Argued May 3, 1982.

Decided Aug. 18, 1982.*

Rehearing and Rehearing In Banc
Denied Oct. 8, 1982.

Before CUMMINGS, Chief Judge, COFFEY, Circuit Judge, and TEMPLAR, Senior District Judge.**

COFFEY, Circuit Judge.

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* This opinion is being released first in typewritten form on August 18, 1982 because the order in *Continental Manors, Inc.* v. *Schweiker*, No. 82-1065 refers thereto.

** The Honorable George Templar, Senior District Judge for the United States District Court for the District of Kansas, is sitting by designation.

Consolidated in this case are appeals from four separte orders of the United States District Court for the Southern District of Indiana, Indianapolis Division.[1] Each of the orders appealed from granted the plaintiffs' request for injunctive relief prohibiting the defendants from terminating the plaintiffs' participation in the Medicare program and/or from terminating the payment of matching funds from Medicaid services without affording plaintiff an opportunity for a pre-termination hearing. We reverse.

The circumstances leading to the grant of injunctive relief in each case appealed from are set out below.

1. AMERICANA-ELKHART

Prior to October, 1980 Americana Healthcare Center of Elkhart ("Americana-Elkhart") located in Elkhart, Indiana had been certified to participate in the Medicare program as a skilled nursing facility and had entered into a provider agreement with the U. S. Department of Health and Human Services (Department) for the provision of skilled nursing services to eligible patients.

The statutory requirements for participation in the federally funded Medicare program are set forth in Title 18 of the Social Security Act, 42 U.S.C. § 1395 (1976 and Supp. IV, 1980). The U. S. Department of Health and Human Services administers this program which provides health insurance benefits for aged and disabled persons by making payments directly to the institution or individual providing the health service or care. 42 U.S.C. § 1395cc(f)

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1. Judge Cale J. Holder entered the orders appealed from in Appeals Nos. 81-2482, 81-2755, and 81-2783. Judge S. Hugh Dillin entered the order appealed from in Appeal No. 81-1522 and Judge James E. Noland entered the order appealed from in Appeal No. 81-1507.

(1976 and Supp. III, 1980). In order to receive payment for services rendered to a Medicare patient, an institution must meet the conditions of participation prescribed by the Social Security Act and and accompanying regulations. *See* 42 U.S.C. § 1395 (1976 and Supp. III, 1980) and 42 C.F.R. § 405.1011 *et seq.* (1982).[2] If an institution meets the conditions of participation it then becomes eligible to execute and enter into a one-year renewal provider agreement with the United States Government. 42 U.S.C. § 1395cc (1976 and Supp. III, 1979). Institutions certified as Medicare providers are subject to periodic surveys by state agencies designated by the Secretary to evaluate compliance with federal standards.[3] 42 U.S.C. § 1395aa (1976 and Supp. IV, 1980) and 42 C.F.R. § 405.1904 (1981). If the institution fails to maintain compliance with the prescribed conditions of participation, a report of the survey is sent to the Secre-

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2. There are 18 "conditions" that nursing homes are required to meet. Each condition relates to one broad aspect of the facilities' operations such as "medical direction" or "nursing services." Each condition of participation is divided into subparts known as "standards." Examples of standards include "coordination of medical care" or "rehabilitative nursing care." Standards are further broken down into elements, which are regulatory requirements such as "presence of marked spaces for parking by the handicapped," or the establishment of procedures for recording deviations in the patient's food or fluid intake. A deficiency is a failure to comply with some "element" of a standard. When several elements are deficient a "standard" is not met and if enough standards are not met a finding is made that a facility does not meet a given "condition of participation."

3. Pursuant to 42 U.S.C. § 1395aa (1976 and Supp. IV, 1980) the Secretary of the U.S. Department of Health and Human Services is authorized to appoint a State health agency or other appropriate State agency (or local agencies) to conduct surveys of the skilled nursing facilities and inspect the physical plant and operational activities of the facility. In these consolidated cases the Indiana State Board of Health conducted the surveys made on behalf of the U.S. Department of Health and Human Services.

tary of the U. S. Department of Health and Human Services and the Secretary then has the authority to terminate the institution's provider agreement at any time or decline to renew the provider agreement at the close of the one-year period. 42 U.S.C. § 1395cc(b)(2) (1976 and Supp. III, 1979) and 42 C.F.R. § 489.53(a)(3) (1980).

A letter dated October 22, 1980 from the U. S. Department of Health and Human Services notified Americana-Elkhart that an onsite survey conducted by the Indiana State Board of Health in August of 1980 demonstrated that Americana-Elkhart had deficiencies which "seriously limit your [their] capabilities to render adequate care and insure the health and safety of your [their] patients" and that the Department would not renew Americana-Elkhart's provider agreement with the Department which expired on December 1, 1980.[4] The Department's letter informed Americana-Elkhart that it could request that the Department through its subdivision, the Health Care Financing Administration, to reconsider its decision within 60 days of

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4. Attached to the Department's October 22, 1980 letter was a four page summary of the deficiencies found in the Americana-Elkhart facility.

Among the items listed in the Statement of Deficiencies was the finding that the facility did not meet the Nursing Services Condition of Participation due to deficiencies such as the lack of sufficient nurse staff coverage, and the lack of documentation that physician and medication orders were being followed. The statement of deficiencies also listed other deficiencies including but not limited to the finding that medications in the drug cart used in passing medications were not patient identified, therapeutic menus were not planned in writing, and patient medical records lacked physicians' progress notes at the time of their visits.

the notice.[5] The letter also requested that the Department be advised within 10 days of the notice if the listed deficiencies had been corrected.

Americana-Elkhart requested a reconsideration and an evidentary pre-termination hearing of the Department's decision, asserting that it had corrected most of the deficiencies and asking that publication of notice of nonrenewal be deferred pending reconsideration. The Department denied the request for an evidentiary pre-termination hearing but pursuant to Americana-Elkhart's request for reconsideration, a resurvey of the facility was conducted. On the basis of the resurvey results showing that the facility was still not in compliance with all Medicare conditions of participation, the Department reaffirmed its decision to deny renewal of Americana-Elkhart's provider agreement. After the resurvey the Department informed Americana-Elkhart of its decision and included with its letter a list of the facilty's continuing deficiencies. In addition, the letter stated that the effective date of the nonrenewal would be extended until January 21, 1981 to allow adequate time for public notice to residents or their families to allow them to find alternative facilities in which they could receive care. Finally, the letter informed the facility of its right to request within 60 days an administrative hearing before an Administrative Law Judge.

42 C.F.R. § 442.20(b) (1981) requires that a state Medicaid agency *must terminate* or refuse to renew a Medicaid

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5. A reconsideration is authorized by 42 CFR § 405.1510-1519 (1981). During a reconsideration the Secretary or his appropriate agent reviews the findings on which the original decision was based and any new evidence submitted by the facility within a reasonable time and either affirms or revises the initial decision.

agreement it has with a facility once the U.S. Department of Health and Human Services decides to terminate or refuse to renew a Medicare agreement with a skilled nursing facility.[6] Thus as a result of the U.S. Government's determination that Americana-Elkhart was not eligible for continued participation in the Medicare program the Indiana Department of Public Welfare decertified the nursing home from participation in the Indiana Medicaid program.

On January 27, 1981 the plaintiffs brought this action in the federal district court alleging that the administrative procedures allowing only for a post-termination hearing violated the Due Process Clause of the United States Constitution and the federal statutes. In addition, the complaint alleged that the U.S. Department of Health and Human Services' refusal to grant a pre-termination hearing made it an appealable final order of an administrative agency under 42 U.S.C. § 405(g) (Supp. IV, 1980).

Following a hearing the district court granted a preliminary injunction prohibiting the U.S. Department of Health and Public Services and the Indiana Department of Public Welfare from terminating the plaintiff's par-

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6. 42 CFR 442.20(b) (1981) provides:

§ 442.20 Additional requirements for agreements with SNF's participating in Medicare.

* * *

(b) If the Secretary notifies the Medicaid agency that he has denied, terminated, or refused to renew a Medicare agreement with a SNF, the agency must deny, terminate, or refuse to renew its Medicaid agreement with that SNF. The denial, termination, or refusal to renew the Medicaid agreement must be effective on the same date as the denial, termination, or refusal to renew the Medicare agreement.

ticipation in the Medicare and/or Medicaid program without a pre-termination hearing.[7]

2. AMERICANA-MIDTOWN

Americana Health Care Center of Indianapolis-Midtown (Americana-Midtown) was another certified skilled nursing nursing facility participating in the Medicare program prior to October, 1980. By letter dated Otcober 24, 1980 the U.S. Department of Healthan Human Services notified Americana-Midtown that based upon the results of an onsite survey conducted from August 25 to 29, 1980 it had determined that Americana-Midtown had deficiencies that "seriously limits your [their] capability to render adequate care and insure the health and safety of your [their] patients" and thus the Department would not renew its provider agreement with Americana-Midtown which was scheduled to end December 1, 1980. Attached to the letter was a four-page statement of deficiencies which formed the basis for the nonrenewal.[8]

The U.S. Department of Health and Human Services letter also informed the facility of its right to request that the Department reconsider its decision. Americana-Mid-

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7. Americana Health Care Corporation owns both the Americana-Elkhart facility and the Americana-Midtown facility. Because of this identity of ownership the Americana Health Care Corporation brought its challenge to the pre-termination procedures applied by the U.S. Department of Health and Human Services in both the Americana-Midtown and Americana-Elkhart cases in a single action.

8. Among the listed deficiencies were the following: insufficient nurse staff coverage, rehabilitative nursing care services not performed daily, treatments being performed either without physicians' orders or not according to such orders, lack of a clean interior, ineffective aseptic procedures, and food not stored, prepared or served under sanitary conditions.

town requested reconsideration contending that it had corrected the majority of the alleged deficiencies. The Indiana State Board of Health as agent of the U.S. Department of Health and Human Services conducted a resurvey of the facility and based upon the results of that resurvey reaffirmed its original decision not to renew Americana-Midtown's provider agreement but extended the effective date of the non-renewal to January 31, 1981 to allow adequate time for public notice to allow the transfer of patients to an eligible and certified facility. The Department informed the facility of its decision by letter detailing the deficiencies of the nursing home and informing the plaintiff of its right to request a hearing within 60 days. In addition to the request for a resurvey, the plaintiff also requested that the defendant conduct a pre-termination evidentiary hearing which request was subsequently denied by the U.S. Department of Health and Human Services.

In accordance with the provisions of 42 C.F.R. § 442.20 (b) the Indiana Department of Public Welfare also decertified Americana-Midtown as a Medicaid provider based upon the Department of Health and Human Services nonrenewal decision and the facility's deficiencies.

[1] On January 27, 1981 this action was filed in the district court seeking to enjoin the Department of Health and Human Services and the Indiana Department of Public Welfare from enforcing the nonrenewal decision against both Americana-Midtown and Americana-Elkhart.[9] The district court granted the preliminary injunction, holding that the plaintiffs had shown that they would suffer irreparable harm if injunctive relief was not ordered pend-

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9. See footnote 7 regarding the common ownership of the two facilities.

ing resolution of the question of the plaintiffs' entitlement to a pre-termination hearing.[10]

3. TURTLE CREEK CONVALESCENT CENTERS, INC.

On November 3 through 7, 1980 an annual survey was conducted by the Indiana State Board of Health of the Turtle Creek Convalescent Centers' nursing home facility known as the Northside Healthcare Center. The Department of Health and Human Services concluded, based upon the survey done at its request, that the survey results demonstrated that the nursing home had deficiencies that

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10. During the preparation of this opinion the court received notice that both Americana-Midtown and Americana-Elkhart have been recertified for Medicare participation effective April 27, 1982 and April 29, 1982 respectively. Upon receipt of this notice the court requested that the parties submit a statement on whether the issues on appeal are moot in view of the recertification. After consideration of the statements of the parties, including the plaintiffs' response to the government's statement, submitted pursuant to our request we determine that the issues raised by the appeal in# 81-1522 *Americana Healthcare Corp.* v. *Schweiker* are not moot because resolution of the issues presented herein is necessary to a proper determination of the question of whether the nursing facility was validly decertified during the period extending from the date of the initial decertification until the date of effective reinstatement. In its statement to the court on the question of mootness the U.S. Department of Health and Human Services raised for the first time the question of its right to recover payments made to the Americana Healthcare facilities during the pendency of this appeal. Because neither party has argued or briefed the issue of the government's right to recover the Medicare payments, we decline to reach this issue on appeal. Further, the resolution of the issues presented herein serves the public interest by resolving an issue which otherwise is likely to recur, that is the question of entitlement to pre-termination hearings and the limitations on district court review of decertification decisions prior to an agency's "final decision."

"seriously limit your [their] capability to render adequate care and insure the health and safety of your [their] patients." Based upon the deficencies revealed during the survey the Department decided not to renew the plaintiff's provider agreement which was scheduled to end March 1, 1981. The Department informed the plaintiffs of its decision by means of a letter dated January 22, 1981. The letter listed the deficiencies found during the survey and informed the facility of its right to request reconsideration of the nonrenewal decision.[11]

Turtle Creek requested reconsideration of the decision not to renew the provider agreement. Pursuant to the request for reconsideration the Department attempted to conduct a resurvey of the facility on February 9, 1981. The resurvey, however, was not completed when Turtle Creek's administrator objected and requested that the survey be discontinued after he was informed that the resurvey results would be based upon records of patient care kept before the date of the first survey as well those kept thereafter. Despite the fact that the reconsideration survey was not completed, the inspectors determined that the facility was still not in compliance with the conditions for continued participation in the Medicare program.

Turtle Creek, like the other plaintiffs in this case, requested that the U.S. Department of Health and Human Services conduct an evidentiary pre-termination hearing which request was denied by the Department.

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11. Among the deficiencies listed by the Indiana State Board of Health were the following: nursing services not being provided to patients in need of such services, no active rehabilitation program in feeding, bladder training, ambulation and self-care services, patient records lacked pertinent information regarding patient condition, assessment, and treatment, and presence of unsanitary conditions relating to dietetic services.

Pursuant to the mandatory requirements of 42 C.F.R. § 442.20(b) the Indiana Department of Public Welfare decertified Turtle Creek as a provider under the Indiana Medicaid program, upon receiving notice of the U.S. Department of Health and Human Services' decision not to renew Turtle Creek's provider agreement.

Prior to the effective date of the nonrenewal decision, Turtle Creek brought this lawsuit alleging that the failure of the state and federal agencies to afford Turtle Creek a hearing prior to termination from both the Medicare and Medicaid programs violated Turtle Creek's constitutional right to due process as well as federal and state statutes. Turtle Creek sought injunctive relief prohibiting the termination of Turtle Creek's participation in the Medicare and Medicaid programs without a pre-termination hearing.

The court granted a temporary restraining order on the date the complaint was filed and scheduled a bench trial to commence shortly thereafter. At the conclusion of trial the court entered a permanent injunction prohibiting the defendants from decertifying Turtle Creek's facility relating to any decertification proceeding initiated prior to the date of the injunction and further enjoining the defendants from decertifying the Turtle Creek nursing home in any subsequent proceeding until such time as the defendants accord Turtle Creek a pre-termination evidentiary hearing.

The district court based this order upon its finding that it had jurisdiction over the parties pursuant to 28 U.S.C. § 1331(a) and § 1361 (1976 and Supp. IV, 1980) and the administrative appeal provisions of 5 U.S.C. § 701 and § 705 (1976). The court also held that a pre-termination hearing was required under the provisions of the Omnibus Reconciliation Act of 1980, P.L. 96-499, § 916(b)(2) amending § 1910 of the Social Security Act, 42 U.S.C. § 1396i(a)

(1) (Supp. IV 1980). The court further found that no emergency existed in any area that would require the immediate termination of participation in the Medicare-Medicaid programs and that the failure to accord the plaintiff a pre-termination hearing was a violation of Turtle Creek's right to due process under the law.

4. CARE INNS, INC.

On May 11 through 14, 1981 an onsite survey was conducted at the Clarksville Healthcare Center, a Medicare skilled nursing facility owned by Care Inns, Inc. Based upon the results of this survey demonstrating that the facility failed to comply with Medicare conditions of participation and based upon a prior plan of corrections submitted by Care Inns on June 5, 1981, in response to the notice of deficiencies in the facility received at the time of the survey, the U.S. Department of Health and Human Services refused to renew Care Inns' Medicare provider agreement that was scheduled to terminate on September 1, 1981.[12] The Department notified Care Inns of this decision by letter dated July 22, 1981 in which the Department further informed Care Inns that the results of the survey showed that the facility had deficiencies which seriously limited the facility's capability to render adequate care and "immediately jeopardized the health and safety of the

12. The statement of deficiency listed, among other items, the following: instances when proper nursing care was not being provided to patients in need of such care, treatment and medication being administered contrary to physicians' orders, supervision of nursing services inadequate, failure to notify physician in case of patient with recent leg amputation having pain, presence of unsanitary conditions relating to dietetic services, required medications frequently unavailable, and no written procedures for preventing spread of infection from linens and dressings.

patients." Attached to the letter was a six-page statement listing the deficiencies found during the survey. The letter also informed Care Inns of its right to request reconsideration of the nonrenewal decision and of the possibility that Department officials would meet with representatives of the facility to discuss the survey findings prior to the nonrenewal deadline.

Care Inns requested a resurvey and responded to the cited deficiencies contending that the facility was now in compliance with all Medicare conditions of participation. Pursuant to Care Inns' request a resurvey of the facility was conducted on August 10 and 11, 1981. The resurvey demonstrated that in several respects the facility continued to fail to provide the proper and required nursing care to its patients. In addition to the resurvey a meeting was held between Care Inns' representatives and officials of the U.S. Department of Health and Human Services in which Care Inns was afforded an opportunity to respond to the resurvey findings and submit new evidence of compliance.

At the time the plaintiff requested a resurvey it also requested a pre-termination evidentiary hearing which request was denied by the defendant.

On August 31, 1981 Care Inns filed this action in the district court making substantially the same allegations as contained in the Americana and Turtle Creek complaints. By agreement of the parties a bench trial on the merits was consolidated with the preliminary injunction hearing. The district court, in its findings of fact and conclusions of law held that, in fact, "no emergency" existed at the time of the survey justifying the Department's refusal to afford a pre-termination hearing. The court further held that the Department's decision not to renew the provider

agreement was an appealable final order of an administrative agency under 5 U.S.C. § 701 and § 705. The court held that its subject matter jurisdiction over the case existed under 28 U.S.C. § 1331(a) (federal question jurisdiction) and in fact the failure of the defendants to afford a pretermination hearing violated the provisions of the federal Omnibus Reconciliation Act of 1980 § 916(a).

In the alternative, the court concluded that both the federal and state defendants failed to provide the plaintiff with a hearing in violation of § 405(g) and/or the Indiana Administrative Adjudication Act. Based upon these holdings the court granted the requested injunction and prohibited the defendants from enforcing the nonrenewal sanction for the year September 1, 1981 through August 31, 1982.

5. R.N. NURSING HOME

The Indiana Department of Public Welfare notified the R.N. Nursing Home (R.N.) by letter dated December 4, 1979 that it was going to be decertified as a Medicaid intermediate care facility because it failed to comply with the conditions of participation in that program. The Indiana Department's action was based upon the results of a survey conducted at the home which revealed numerous deficiencies in the facility. The letter sent by the Indiana Department of Public Welfare notified the facility that it had 15 days to file written objections to the decision and to request an administrative redetermination.

Subsequently, R.N. Nursing Home requested the Indiana Department of Public Welfare to hold a hearing prior to any decertification action. Upon agreement of the parties this hearing was postponed pending the outcome of a state licensure proceeding involving R.N.'s state nursing home license. The licensure proceedings were completed on Au-

gust 18, 1980 with a recommendation that the home be accorded a full license.

On September 23, 1980 the Regional Medicaid Director of the Federal Health Care Financing Administration notified the Indiana Department of Public Welfare by a letter that the state's claim for federal matching funds for Medicaid payments made to R.N. Nursing Home was being recommended for deferral because of the determination that R.N. was not in compliance with the Medicaid intermediate care facility conditions of participation.[13]

Under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (1976 and Supp. IV, 1980) the Medicaid program is established as a cooperative federal-state program to provide payments for "necessary medical services" rendered to needy individuals. A state is not required to institute a Medicaid program; however, if it chooses to do so it must submit a satisfactory state plan to the U. S. Department of Health and Human Services. The U. S. Department then reviews the plan and if a state plan is approved the state becomes entitled to federal grants reimbursing the state for a portion of the expenditures which it makes to qualified healthcare facilities for providing medicaid services to qualified individuals.

Under 42 U.S.C. § 1396a(a)(33)(B) (1976) the states are responsible for determining whether or not a state facility complies with the federal requirements of participation as a Medicaid intermediate care facility.[14] Once the

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13. The deficiencies found during the survey are not recited in the record on appeal.

14. An intermediate care facility is one kind of medical service which a state may provide under its Title XIX plan. Other types of services such as those provided by a skilled nursing facility can be provided under Medicaid.

facility has been so certified the state Medicaid agency (here the Indiana Department of Public Welfare) may execute a provider agreement with the facility for the provision of services and making of payments under the state plan. The state may not obtain federal reimbursement of expenditures made for services rendered in a facility which has not been certified as meeting federal requirements of participation and which lacks a valid provider agreement.

Under Medicaid the U. S. Department of Health and Human Services does not pay nursing homes directly for the federal government's share of services they have rendered to eligible Medicaid recipients. Rather, the Medicaid payment procedure, set out in 42 U.S.C. § 1396b(d) (1976 and Supp. IV, 1980) requires the Secretary of the U. S. Department of Health and Human Services to estimate the amount due the state for the payments it has made to Medicaid providers based upon the state's report of its expenditures and "such other investigation as the Secretary may find necessary" and adjusted to reflect, *inter alia,* any prior overpayment or underpayment "which the Secretary determines was made for any prior quarter." 42 U.S.C. § 1396b(d)(1), (2). Based on these factors the Secretary then issues a grant award to the state.

A determination by the Secretary that expenditures claimed by the state do not meet federal requirements and, hence, are not reimbursable with federal funds is called a "disallowance." *See* 42 U.S.C. § 1316(d); 45 C.F.R. § 201.14(a), (d), as amended (1981).

42 U.S.C. § 1316(d) (1976) provides for an administrative reconsideration of the disallowance of Title XIX funds to a state:

> Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under . . . (Title XIX) shall be disallowed for such participation, the state shall be entitled to and upon request shall receive a reconsideration of the disallowance.

42 U.S.C. § 1316(d).

Even before a disallowance the Department may defer a decision on the allowability of claims submitted by a state until further evidence is submitted. 45 C.F.R. § 201.15 *et seq.* (1981). The regulations allow the administrator or designate of the Health Care Financing Administration of the U. S. Department of Health & Human Services to defer claims only when the administrator "believes the claim or specific portion is of questionable allowability." 45 C.F.R. § 201.15(c)(1). After a deferral action is taken, the state is given an opportunity to provide documentation concerning the proposed disallowance of the claim. 45 C.F.R. § 201.15(c)(2). After all documentation has been received, the Administrator has 90 days to determine the propriety of allowing of the claim. 45 C.F.R. § 201.15(c)(6). If the U. S. Department disallows the claim the state is given a written notification of the disallowance decision, 45 C.F.R. § 201.15(c)(8), and is permitted another administrative appeal pursuant to 45 C.F.R. § 201.14. 45 C.F.R. § 201.-15(c)(9).

Thus in this case the Federal Healthcare Financing Administration deferred payment of Federal Matching Funds to the Indiana Department of Public Welfare because of the pending decertification action brought by the Indiana Department.

Subsequently, the Indiana Department of Public Welfare, by a letter dated December 19, 1980, notified R. N.

that based upon the Department's interpretation of the relevant Indiana law (Indiana Code 12-1-7-14.9(b)) it was required to defer any payment to the nursing home because federal financial participation was no longer approved and available to the facility. According to the plaintiffs this action was taken without a proper hearing on the question of the termination decision.

The plaintiffs then brought this action seeking a temporary restraining order prohibiting the defendants from discontinuing the reimbursement of R. N. for Medicaid intermediate care services. The plaintiffs alleged that they were entitled to a pre-termination hearing pursuant to 5 U.S.C. § 701 *et seq.*, § 916(b)(2) of the Omnibus Reconciliation Act of 1980, P.L. 96-499 and this court's decision in *Hathaway* v. *Mathews*, 546 F. 2d 227 (7th Cir. 1976). On December 31, 1980, the district court temporarily restrained the defendants from terminating reimbursement for services rendered by R. N. and the parties subsequently agreed to continue the temporary restraining order pending a hearing. The district court on January 27, 1981 ordered that the December temporary restraining order remain in full force and effect pending further order but permitted new administrative proceedings if any new basis for decertification was found.

On March 9, 1981, the Indiana Department of Public Welfare petitioned the district court to amend its temporary restraining order to permit the removal of patients from the home pursuant to a subsequent decertification action. The court denied this petition on March 19, 1981, holding that the subsequent decertification action was interrelated to the pending action and therefore was more in the nature of a "continued" decertification action than a new action and thus came within the parameters of the prohibitions recited in the temporary restraining order.

ISSUES

(1) Did the district courts have subject matter jurisdiction of each of the consolidated cases?

(2) Did the district courts properly exercise pendent jurisdiction over the state claims in the Care Inns case?

SUBJECT MATTER JURISDICTION

A. FEDERAL QUESTION JURISDICTION

[2] In each of the consolidated cases the defendants challenged the courts' subject matter jurisdiction over the action. The district courts in each instance rejected this argument holding that subject matter jurisdiction existed based upon either Federal Question jurisdiction, 28 U.S.C. § 1331, Social Security Act Appeal jurisdiction, 42 U.S.C. § 405(g), Federal Mandamus jurisdiction, 28 U.S.C. § 1361, or Administrative Appeals jurisdiction, 5 U.S.C. § 701 *et seq.*[15]

We must begin our analysis by pointing out that the holdings of the district courts in each of these cases predated the decision of this court in *Northlake Community Hospital* v. *United States of America*, 654 F. 2d 1234 (7th Cir. 1981) in which the question of the district court's subject matter jurisdiction over actions challenging the termination of Medicare and/or Medicaid provider agreements was specifically addressed and the district courts were thus without the benefit of that opinion.

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15. In this appeal the plaintiffs no longer continue to assert that subject matter jurisdiction exists under the provisions of 5 U.S.C. § 701 *et seq.* The decision of the United States Supreme Court in *Califano* v. *Sanders*, 430 U.S. 99, 97 S. Ct. 980, 51 L. Ed. 2d 192 (1976)establishes that in fact no such subject matter jurisdiction exists under the Administrative Procedure Act. *Id.* at 107, 97 S. Ct. at 985.

Northlake was an appeal from a dismissal of a suit for injunctive relief brought by the Northlake Hospital seeking to prohibit the U. S. Department of Health and Human Services from terminating the hospital's Medicare provider agreement without first affording it a pre-termination administrative hearing. This court began its analysis of the district court's dismissal of the lawsuit for lack of subject matter jurisdiction by recognizing that consistent with the United States Supreme Court's decision in *Weinberger* v. *Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), 42 U.S.C. § 405(h) precludes the use of 28 U.S.C. § 1331 as a jurisdictional basis for challenging Medicare provider termination decisions.

> In *Trinity Memorial Hospital of Cudahy, Inc.* v. *Associated Hospital Services*, 570 F. 2d 660 (7th Cir. 1977), this court agreed that *Salfi* 'precludes the use of 28 U.S.C. § 1331 as a jurisdiction basis' for Medicare provider reimbursement disputes. Although Northlake's claim in the instant case involves the procedures for terminating a provider agreement rather than the procedures for obtaining reimbursement pursuant to such an agreement, the result with respect to these two procedures should be the same. Under *Salfi* and *Trinity*, Northlake's allegation of federal question jurisdiction is defective.

Northlake, 654 F. 2d at 1240.

This holding is applicable to the cases at bar and precludes the district court from establishing subject matter jurisdiction over the cases based upon federal question jurisdiction.

B. JURISDICTION UNDER 42 U.S.C. § 405(g)

[3] The court continued its analysis in *Northlake* and considered whether subject matter jurisdiction was con-

ferred upon the district courts by 42 U.S.C. § 405(g). It was recognized that Title XVIII of the Social Security Act specifically states that an institution dissatisfied with a final decision of the Secretary of the Department of Health and Human Services to terminate its Medicare provider agreement may obtain judicial review of the decision pursuant to 42 U.S.C. § 405(g). 42 U.S.C. § 1395ff(c). However, the court noted that § 405(g) permits review only where the three requirements set forth therein have been complied with:

> Under the terms of Section 405(g), review is available only if three requirements have been satisfied: (1) an action was brought 'after any final decision of the Secretary made after a hearing to which [the provider] was a party;' (2) the action was commenced within 60 days after the mailing of the notice of decision by the Secretary or within such time as the Secretary may allow; and (3) the action was filed in an appropriate court. 42 U.S.C. § 405(g) (1979).

Northlake, 654 F. 2d at 1240.

This court then pointed out that the Supreme Court in its *Salfi* opinion held that the first requirement of § 405(g) jurisdiction is a final decision by the Secretary after a hearing and this first requirement is "central to the requisite grant of subject-matter jurisdiction" *Salfi,* 422 U.S. at 764, 95 S.Ct. at 2466. In the cases consolidated in this appeal, as well as in *Northlake,* the plaintiff Medicare-Medicaid providers did not exhaust their available administrative remedies prior to the filing of these lawsuits and thus have not received the "final decision" of the Secretary required for 42 U.S.C. § 405(g) jurisdiction.

The plaintiffs in the case at bar argue, however, as did Northlake Hospital, that they fall within an exception to the final decision requirement.

In *Mathews* v. *Eldridge*, 424 U.S. 319, 96 S. Ct. 893, 47 L.Ed.2d 18 (1976) the Supreme Court found that there are two prerequisites to a final decision under § 405(g). The first of these prerequisites is the presentation of a claim for benefits. This element is nonwaivable and absent such a claim there can be no appealable decision of any type. *Id.* at 329, 96 S.Ct. at 900. In each of the cases at bar the parties challenge the decision to terminate their provider status along with challenging the administrative body's failure to allow them a pre-termination hearing and thus they have satisfied this first element.

The second prerequisite to a "final decision" under § 405(g) set forth in *Mathews*, 424 U.S. at 329, 96 S.Ct. at 900, requires the exhaustion of administrative remedies and this element is waivable by the Department of Health and Human Services. *Id.* at 328, 96 S.Ct. at 899. In addition to being waivable by the Department the decision of the United States Supreme Court in *Mathews* establishes that this exhaustion requirement may also be waived where the plaintiff raises a colorable constitutional challenge which is entirely collateral to his claim of entitlement and the claimant's interest in having this issue resolved is so great as to make deference to the agency's judgment inappropriate. *See Mathews*, 424 U.S. at 331, 332, 96 S.Ct. at 900-01; *Northlake*, 654 F. 2d at 1243.

In the instant cases as in *Northlake* the plaintiffs argue that the alleged due process violation arising out of the failure to afford a pre-termination hearing constitutes a colorable constitutional claim sufficient to permit a waiver of the exhaustion prerequisite of § 405(g). Similar arguments regarding constitutional entitlement to a pre-termination hearing under the due process clause were specifically rejected by this court in *Northlake*, 654 F. 2d at

1241-1243 and the rationale of that opinion rejecting the constitutional due process claim is equally applicable to the cases consolidated in this appeal.

Each of the plaintiffs in the cases consolidated herein was afforded advance notice of the decision to decertify their respective facility as a Medicare and/or Medicaid provider. In addition, each was informed of the deficiencies upon which the decision to decertify the facility was based and was afforded an opportunity for a resurvey to demonstrate any corrections made in the listed deficiencies and each was permitted to submit documentation explaining or refuting the existence of the deficiencies. In the case of Care Inns, Inc. the facility was also permitted to meet with personnel of the Department of Health and Human Services and submit evidence of compliance with applicable conditions of participation prior to termination. Weighing the benefits of these procedural protections, the interest in efficient and not unduly expensive administrative procedures as well as the strong government interest in the protection of Medicare and Medicaid recipients against the risk that a facility will be erroneously terminated as a Medicare or Medicaid provider, we conclude that the plaintiffs have failed to establish a colorable claim of constitutional entitlement to a pre-termination hearing.

The plaintiffs have argued that the prior decision of this court in *Hathaway* v. *Mathews*, 546 F. 2d 227 (7th Cir. 1976) supports the contrary conclusion that the plaintiffs are constitutionally entitled to a pre-termination hearing.[16] The *Hathaway* decision predated the later *Northlake* decision and was factually distinguished in a footnote therein.

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16. Initially it can be pointed out that the *Hathaway* decision did not address the question of jurisdiction which is the basis of both the *Northlake* and the present opinion.

654 F. 2d at 1243 n.10. In *Hathaway* the Medicaid facility was terminated from the Medicaid program by the U.S. Department of Health and Human Services acting independent of the state Medicaid agency and it did not receive notice of the alleged deficiencies, nor was a post-termination hearing available to it under the applicable regulations. This is contrasted with the fact situations presented here, wherein each of the plaintiffs received written notice of the alleged deficiencies and had post-termination procedural protections available to them. To the extent that *Hathaway* remains good law within the circuit it is limited to its unique factual situation, including a lack of prior notice of deficiencies from the terminating agency and the absence of post-termination appeal procedures.

Laura Hathaway, plaintiff in case No. 81-1507 consolidated in this appeal, specifically argues that the facts of her case more nearly resemble those of the earlier *Hathaway* decision than those of *Northlake*. The *Hathaway* case consolidated in this appeal differs from the earlier *Hathaway* decision, however, because in the case at bar the facility was decertified initially by the state Medicaid agency acting on its own rather than on behalf of the U.S. Department of Health and Human Services and it had procedures available to it through which it could challenge the state's determination. In addition, the federal Department of Health and Human Services merely *deferred* reimbursement to the state for services rendered by R.N. Nursing Home pending resolution of the decertification question. The fact that the state Medicaid agency failed to challenge the deferral of repayment does not provide the home with a colorable constitutional claim upon which it could assert jurisdiction in a federal court.

In light of our holding that the plaintiffs have not presented a colorable constitutional claim to a due process

pre-termination hearing, we conclude that the district courts in the present action did not have subject matter jurisdiction over the consolidated cases pursuant to 42 U.S.C. § 405(g).

C. MANDAMUS JURISDICTION

In the alternative, the plaintiffs have asserted that the district courts had mandamus jurisdiction over the cases consolidated in this appeal pursuant to the provisions of 28 U.S.C. § 1361. Plaintiffs contend that § 916 of the Omnibus Reconciliation Act of 1980, P.L. 96-499 creates a clear right to a pre-termination hearing and thus the exercise of mandamus jurisdiction on the part of the district courts was proper.

The defendants respond to these arguments by contending that 42 U.S.C. § 405(h)[17] is intended to preclude the exercise of mandamus jurisdiction in the same manner as it precludes the exercise of federal question jurisdiction over decisions appealable under the provisions of the Social Security Act. They argue that consistent with principles of statutory construction § 405(h) should be read as encompassing the statutory addition of mandamus jurisdiction within the jurisdictional exclusions of § 405(h).

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17. 42 U.S.C. § 405(h) provides:

> Finality of Secretary's decision. The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

The defendants further argue that § 916 of the Omnibus Reconciliation Act does not create a clear right to a pre-termination hearing under the facts of these cases even if the district courts are entitled to exercise mandamus jurisdiction over the decisions made under the Social Security Act and thus the exercise of mandamus jurisdiction in these consolidated cases was inappropriate.

[4] Independent of the question of whether § 405(h) bars mandamus jurisdiction in cases brought under the provisions of the Social Security Act, it is well established in case law that mandamus jurisdiction may be invoked only where the following three elements are present:

Mandamus may properly issue only when three elements are present:

> (1) a clear right in the plaintiff to the relief sought;
> (2) a plainly defined and peremptory duty on the part of the defendant to do the act in question;
> (3) no other adequate remedy available.

Lovallo v. *Froehlke*, 468 F. 2d 340, 343 (2nd Cir. 1972). *Cervoni* v. *Secretary of Health, Education and Welfare*, 581 F. 2d 1010, 1019 (1st Cir. 1978).

[5] Regarding the first of these elements it is also established that the mandamus remedy is only available "under exceptional circumstances of clear illegality." *Id.* at 1019.

> When the performance of official duty calls for a construction of governing law, the [federal] officer's interpretation will not be disturbed by a writ of mandamus unless it is clearly wrong and his official action is arbitrary and capricious.

Association of American Medical Colleges v. *Califano*, 569 F. 2d 101, 110 n.80 (D.C. Cir. 1980).

[6] The plaintiffs in the cases consolidated in this appeal assert that recent changes made in the Social Security

Act by § 916 of the Omnibus Reconciliation Act of 1980, P.L. 96-499 established their clear right to a pre-termination hearing. Specifically the plaintiffs contend that subpart (a) of § 916 is applicable to the case at bar. That section provides:

> ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY
>
> SEC. 916. (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection:
>
> "(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which as been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—
>
> "(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or
>
> "(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide
>
> that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.
>
> "(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a

> reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

The plaintiffs argue that subpart 2 of the new subsection requires a hearing prior to the date of any termination or decertification of a Medicare skilled nursing facility.

The plaintiffs' interpretation of subpart 2 is based upon their conclusion that the phrase "such a decision" refers to the Secretary's determination of whether the facility's deficiencies "immediately jeopardize the health and safety" of the patients. This construction of subpart 2 is essential to the plaintiffs' interpretation of the statutory provision because a construction of the phrase "such a decision" as applying solely to the Secretary's decision in subpart (1)(B) of whether to impose an alternative sanction would require a pre-termination hearing only in those situations where the Secretary determines that the facility's deficiencies do not "immediately jeopardize" the health and safety of the patients. In each of the cases consolidated in this appeal in which the Secretary determines that a facility did not substantially meet the Medicare conditions of participation the Secretary concluded that a situation of "immediate jeopardy" existed.[18]

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18. In the cases of Americana-Elkhart, Americana-Midtown, and Turtle Creek the Secretary's letter to the facility used the phrase "seriously limit your [their] capability to render adequate care and insure the health and safety of your [their] patients" when informing the facility that it did not substantially meet the Medicare conditions of participation. This phrase is interpreted as being equivalent to a finding of "immediate jeopardy." The brief of all the plaintiffs to this appeal concedes as much in Footnote 10 of their brief in which they argue that the Secretary's determination of "immediate jeopardy" is not substantiated by the record.

To construe the phrase "such a decision" in the manner in which the plaintiff asserts is appropriate leads one to the anomalous situation of permitting a skilled nursing facility to continue treating patients under conditions which the Secretary has concluded place the patients' very health and safety in "immediate jeopardy" while the facilities are afforded a time consuming pre-termination hearing. It is ludicrous to believe that the legislature intended to permit the appeal procedures to act as a roadblock to the prompt removal of patients for their own protection and safety from substandard facilities.

The plaintiffs argue that the need for haste in terminating a skilled nursing facility is not a purpose of the new provision because considerable delay occurs under the present procedure during the resurvey and notice period. The existence of this time-lag does not justify further delay in termination or nonrenewal but merely supports our earlier conclusion that the current procedures already afford the plaintiffs more than adequate due process.

The plaintiffs' construction of the phrase "such a decision" is also inconsistent with the use of the mandatory term "shall" in subsection (1)(A) of the provision. The use of the mandatory term "shall" requires the termination sanction in cases where the conditions of "immediate jeopardy" to health and safety are found to exist.

Thus we conclude that a common sense reading of the statutory provision leads to the conclusion that a pre-termination hearing is not required where the Secretary determines that a situation of "immediate jeopardy" exists.

The limited legislative history available concerning the code provisions added by § 916 of the Omnibus Reconciliation Act supports our interpretation of the legislation. The

House Report on Public Law 96-499 explains that the purpose of the new Code provisions was to provide an alternative sanction to termination in cases where "immediate jeopardy" to patients' health and safety did not exist:

> At present, the only sanction available in many jurisdictions to penalize a skilled nursing facility which is out of compliance with the conditions of participation in the Medicare and Medical [sic] programs is to terminate that facility's participation in the program. Frequently, this sanction involves an overriding hardship to program beneficiaries which makes its use desirable [sic], if not impossible.
>
> * * *
>
> In the case of facilities that are substantially out of compliance but do not have deficiencies that immediately jeopardize the health and safety of their patients, the section gives the Secretary authority to impose an intermediate sanction, short of the more drastic step of program termination.
>
> * * *
>
> Under the provision, a facility would have an opportunity to develop and implement a plan for correcting its deficiencies, in accordance with existing Medicare policies on the correction of provider deficiencies. Following the facility's failure to satisfactorily meet this requirement, the Secretary could apply intermediate sanctions, but only after the Secretary has provided the facility with an opportunity to present its case at an informal hearing consistent with current practices. If the facility seeks further administrative or judicial appeals, the sanction would remain in effect while the appeals were pending.

House Report No. 96-1167, reported in (1980), U.S. Code Cong. & Ad. News, 96th Congress 2d Sess. 5526, 5569.

Later in that same report, however, it is made clear that the prompt termination sanction was intended to remain applicable in cases of "immediate jeopardy."

> [T]he committee believes that this sanction should not be used as an alternative in situations where a noncomplyng facility's deficiencies place the health and safety of its patients in immediate jeopardy; instead, the response for the Secretary in such cases must be to deny all reimbursement of additional patients and to make appropriate arrangements for the orderly, planned transfer of existing patients.

Id. at 5570.

The legislative history and plain language of § 916(a) of the Omnibus Reconciliation Act mandate the conclusion that the Code provision does not create a clear right on the part of the plaintiffs to a pre-termination hearing in situations where the Secretary determines that the facility's deficiencies placed the patients' health and safety in "immediate jeopardy."

The plaintiffs argue that several of the district courts found that, in fact, no situation of "immediate jeopardy" or emergency existed. This factual conclusion is more appropriately deferred to the expertise of the licensing agency and it is not a proper consideration for a court under mandamus jurisdiction where a clear right to a pre-termination hearing is required and a federal officer's interpretation "will not be disturbed unless it is clearly wrong." *Association of American Medical Colleges* v. *Califano*, 569 F. 2d at 110 n.80.

Deference to the expertise of professionals who are trained and experienced in evaluating the compliance of Medicare or Medicaid facilities with federal regulations is consistent with recent decisions of the United States Supreme Court cautioning against a substitution of a judge's opinion for that of a professional. Most recently in *Youngberg* v. *Romeo*, —— U.S. ——, 102 S. Ct. 2452, 73 L. Ed.

2d 28 (1982) the Court made the following comments regarding deference to a professional's opinion as to appropriate patient care:

> In determining what is "reasonable"—in this and in any case presenting a claim for training by a state—we emphasize that courts must show deference to the judgment exercised by a qualified professional. By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized. Moreover, there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions. See *Parham* v. *J. R.*, 442 U.S. 584, 607 [99 S. Ct. 2493, 2506-2507, 61 L. Ed. 2d 101] (1979); *Bell* v. *Wolfish, supra*, 441 U.S. [520] at 544 [99 S. Ct. 1861 at 1877, 60 L. Ed. 2d 447] (Courts should not " 'second-gues the expert administrators on matters on which they are better informed.' ").

—— U.S. at ——, 102 S. Ct. at 2460.

Absent a clear right to a pre-termination hearing, mandamus jurisdiction is not appropriate in the consolidated cases in this appeal and thus we hold that the district courts were without jurisdiction over these cases.[19]

Because we determine that no clear right existed entitling the plaintiffs to a pre-termination hearing, it is not

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19. The arguments of plaintiff Laura Hathaway to the effect that she is entitled a pre-termination hearing under the "look behind" provisions of § 916(b)(2) of the Omnibus Reconciliation Act are also rejected because the decision to decertify was initially made by the state Medicaid agency and the argument that the decertification action was subsequently abandoned is belied by the state's continuing efforts to decertify the facility. See the State's Emergency Petition to Amend the Court's Entry of January 27, 1981 dated March 9, 1981.

necessary to determine whether 42 U.S.C. § 405(h) precludes mandamus jurisdiction as well as federal question jurisdiction in these cases.

PENDENT JURISDICTION

[7] The sole issue remaining for our consideration is whether the district court in the Care Inns case properly exercised pendent jurisdiction when it determined that the Indiana Administrative Adjudication Act requires a hearing prior to the Indiana Department of Public Welfare's termination of a provider of skilled and intermediate nursing services from participating in the Medicaid program. It is axiomatic that "pendent jurisdiction is a doctrine of discretion, not of plaintiff's right." *United Mineworkers of America* v. *Gibbs,* 383 U.S. 715, 726, 86 S. Ct. 1130, 1138, 16 L. Ed. 2d 218 (1966). Further it is established that a federal court may exercise pendent jurisdiction only where there exists a federal claim of "substance sufficient to confer subject matter jurisdiction on the court." *Id.* at 725, 86 S. Ct. at 1138.

[8] In light of our holding that the district courts were without subject matter jurisdiction over the cases consolidated in this appeal, it is equally clear that the district court could not exercise pendent jurisdiction over the state claim concerning entitlement to a pre-termination hearing under the relevant Indiana Code provisions. Thus the orders of the district court entered in these consolidated cases are REVERSED.

Unpublished Per Curiam Order
Judgment — Oral Argument

UNITED STATES COURT OF APPEALS

For the Seventh Circuit
Chicago, Illinois 60604
August 18, 1982

Before

Hon. WALTER J. CUMMINGS, Chief Judge
Hon. JOHN L. COFFEY, Circuit Judge
Hon. GEORGE TEMPLAR, Senior District Judge*

No. 82-1065

CONTINENTAL MANORS, INC.,
Plaintiff-Appellee.

vs.

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, and KATHLEEN LEAK, Principal Program Representative,
Defendants-Appellants.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

—

No. 81 C 6082

—

J. Sam Perry,
Judge.

This cause was heard on the record from the United States District Court for the Northern District of Illinois, Eastern Division, and was argued by counsel.

On consideration whereof, IT IS ORDERED AND ADJUDGED by this Court that the order of the said District Court in this cause appealed from be, and the same is hereby, REVERSED, with costs, in accordance with the order of this Court entered this date.

*** Honorable George Templar, Senior District Judge for the District of Kansas, is sitting by designation.**

UNITED STATES COURT OF APPEALS

For the Seventh Circuit
Chicago, Illinois 60604
August 26, 1982

Before

Hon. JOHN L. COFFEY, Circuit Judge

No. 82-1065

CONTINENTAL MANORS, INC.,
Plaintiff-Appellee,

vs.

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, and KATHLEEN LEAK, Principal Program Representative,
Defendants-Appellants.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

No. 81 C 6082

J. Sam Perry, *Judge.*

On consideraton of the "MOTION FOR EXTENSION OF TIME" and affidavit in support thereof, filed herein on August 24, 1982, by counsel for the plaintiff-appellee,

IT IS ORDERED that said motion is hereby GRANTED and the time for filing the plaintiff-appellee's petition for rehearing is extended up to and including September 10, 1982.

UNITED STATES COURT OF APPEALS

For the Seventh Circuit
Chicago, Illinois 60604
October 5, 1982

Before

Hon. WALTER J. CUMMINGS, Chief Judge
Hon. JOHN L. COFFEY, Circuit Judge
Hon. GEORGE TEMPLAR, Senior District Judge*

No. 82-1065

CONTINENTAL MANORS, INC.,
Plaintiff-Appellee,

vs.

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, and KATHLEEN LEAK, Principal Program Representative,
Defendants-Appellants.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

—

No. 81 C 6082

—

J. Sam Perry, *Judge.*

ORDER

On consideration of the petition for rehearing and suggestion for hearing *in banc* filed in the above-entitled cause by Continental Manors, Inc., petitioner-appellee, no judge in active service has requested a vote thereon, and all of the judges on the original panel have voted to deny a rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing be, and the same is hereby, DENIED.

*** The Honorable George Templar, Senior District Judge of the United States District Court for the District of Kansas, is sitting by designation.**

APPENDIX B

CONSTITUTION

AMENDMENT [V] to the Constitution of the United States:

> No person shall . . . be deprived of life, liberty, or property, without due process of law; . . . .

STATUTES

28 U.S.C. § 1361. Action to compel an officer of the United States to perform his duty.

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

42 U.S.C. § 405(g). (1976).

Judicial review

(g) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings

and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Secretary made for good cause shown before he files his answer, remand the case to the Secretary for further action by the Secretary, and it may at any time order additional evidence to be taken before the Secretary, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding: and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or its decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner

as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

42 U.S.C. § 405(h). (1976).

Finality of Secretary's decision

(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 1395cc(f) [Section 1866(f) of the Social Security Act] as added by Section 916(a) of the Omnibus Reconciliation Act of 1980, Public Law 96-499, effective December 5, 1980.

(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of

terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.

REGULATIONS

42 C.F.R. § 405.1514 Reconsidered determination.

When a request for reconsideration has been filed as provided in § 405.1511, the Secretary shall reconsider the initial determination in question and the findings on which it was based. The Secretary shall make a reconsidered determination affirming or revising, in whole or in part, the findings and determination in question (see § 405.1515).

42 C.F.R. § 405.1515 Submission of Evidence.

The Secretary will receive in evidence any documents or written statements which are relevant and material to the matters at issue and which are submitted within a reasonable time after the filing of a request for reconsideration. The reconsidered determination will be based on the evidence considered in making the initial determination, taking into account facts relating to the status of the institution, agency, clinic, laboratory, portable X-ray supplier, or end-stage renal disease treatment facility as of a date subsequent to the initial determination.